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The impact of working in eating disorder settings on staff

Section A: Eating Disorders, countertransference and the impact on
clinicians: a review

Section B: “Food for thought and thoughts of food”: A Grounded
Theory analysis of the impact of inpatient eating disorder
environments on staff body image and eating habits

Section C: Appendix of Supporting Material

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*'In a dark place we find ourselves, and a little more knowledge lights our way'-
Yoda*

Summary of major research project

Section A - This section focuses on existing research into countertransference experienced by clinicians working in eating disorder settings. A number of different forms of countertransference have previously been highlighted, including emotional countertransference and physical countertransference. Additionally, working with clients with eating disorders has been linked to changes in clinician's perception of their own body and has been thought to have an impact on team processes. Finally, there is some suggestion that different eating disorder diagnoses may affect the countertransference experienced. However, existing research tends to rely on single case studies and limited samples of clinicians. Furthermore, existing literature into the changes experienced by clinicians utilises the largely psychodynamic/psychoanalytic framework of countertransference, with limited research papers outside of this theoretical orientation.

Section B - This section aimed to develop a model which explains the changes to body image and eating habits experienced by clinicians working in eating disorder settings from a pan-theoretical standpoint. Thirteen members of staff working within two private, adolescent inpatient eating disorder hospitals were interviewed about their previous eating habits and body image, as well as any changes experienced since beginning their work in eating disorder settings. Participants had a wide variety of job roles; however, the majority of participants were healthcare assistants/therapeutic care workers or assistant psychologists. Interviews were analysed using a Grounded Theory approach, and three core categories were developed. These were past perceptions of self, body image and eating, perceived changes and reasoning for changes. A theoretical model was developed to explain the relationship between these categories, and how concepts such as pre-existing body image,

ideas of food, the work environment, access to support, the impact of patients themselves and promotion of chaotic eating through the work itself interplay to create change. How these changes are perceived and managed is then influenced by individual differences and the “personalised meaning” ascribed.

Section C - Appendices

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Section A: Eating Disorders, countertransference and the impact on
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1. ABSTRACT

The countertransference experienced by staff working in mental health settings is an area which has received some attention in psychodynamic and psychoanalytic literature. Eating disorder work represents an area of particular complexity due to the high levels of mortality, suicide, ambivalence to treatment and co-morbidity. However, the countertransference experienced by staff working specifically in eating disorder settings remains a relatively new area of research.

Electronic databases were searched for studies of countertransference that may be experienced by staff working in eating disorder settings. Sixteen studies were identified, which differed in their methodology, clinicians included, and findings. The quality of the studies analysed is considered, and a synthesis of findings is given.

Although there is some evidence to suggest that staff working in eating disorder settings may experience a high level of countertransference, there is a general paucity of research, with most studies being of relatively poor quality and drawing on limited pools of clinicians. Implications for clinical practice and for further research are discussed.

2. INTRODUCTION

2.1 Overview

The term 'Eating Disorders' is an umbrella term applied to a range of psychological disorders, all of which have abnormal eating patterns as their core diagnostic criteria. These abnormal eating patterns result in changes to physical and/or psychological functioning. While a range of disorders fall under this umbrella term, the most common are Anorexia Nervosa, Bulimia Nervosa, Eating Disorder Not Otherwise Specified (EDNOS)/Other Specified Feeding or Eating Disorder (OSFED) and the more recent addition of Binge Eating Disorder (in Diagnostic and Statistics Manual, Fifth Edition, American Psychiatric Association, 2013). Although Binge Eating Disorder is grouped in the same diagnostic category as the aforementioned, it is thought that the underlying mechanism may be more akin to a food addiction as opposed to the idealisation and pursuit of thinness typically observed in Anorexia, Bulimia and EDNOS (Schulte, Grilo & Gearhardt, 2016).

2.2 Prevalence, recovery and mortality rates

Current estimates suggest that around 725,000 people in the UK have an Eating Disorder (PwC & Beat, 2015); however, research suggests that 6.4% of all adults in the UK exhibit some eating disorder symptoms (Health & Social Care Information Centre, 2007). Although the majority of those with eating disorder diagnoses are females, estimates suggest that between eleven percent (National Institute of Clinical Excellence guideline CG9, 2004) and twenty five percent (Beat, 2010) of eating disorders occur in males. Additionally, the number of individuals diagnosed with eating disorders appears to be rising faster in males than in females (Micali, Hagberg, Petersen, & Treasure, 2013). Although eating disorder onset can occur at any age, the average age of onset is between sixteen and seventeen

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years for Anorexia, and between eighteen and nineteen years for Bulimia (National Institute of Clinical Excellence guideline CG9, 2004), with those under the age of twenty accounting for approximately 49% of all eating disorder inpatient admissions (Royal College of Psychiatrists, 2014).

Treatment of Eating Disorders continues to be problematic. Where treatment is prompt, approximately 46% of those with Anorexia and 45% of those with Bulimia will make a full recovery, while 33% of those with Anorexia and 27% of those with Bulimia will show significant improvements. However, 20% of those with Anorexia and 23% with Bulimia will continue to experience long-term, chronic difficulties with eating (Beat, 2010). The chronic nature of eating disorders often results in medical complications, and the psychological difficulties associated with eating disorders can often result in suicide (Harris & Barraclough, 1998). Because of this, Anorexia Nervosa continues to have the highest mortality rate of all mental health conditions (Steinhausen, 2002), with estimates suggesting that Anorexia results in 5.1 deaths per 1000 per year (Arcelus, Mitchell, Wales & Nielsen, 2011).

2.3 Treatment

Treatment of eating disorders continues to remain problematic – largely due to the continued idealisation and pursuit of thinness, lack of insight into the severity of the illness, resistance and distorted view of the self as being overweight commonly seen in those with eating disorders (Vitousek, Watson & Wilson, 1998; Williamson, Muller, Reas & Thaw, 1999). Because of these difficulties, a wide range of psychological therapies are recommended for the treatment of eating disorders, including Psychodynamic Psychotherapy, Cognitive Behavioural Therapy, and Systemic Family Therapy, with limited evidence to suggest that any one therapeutic modality is superior (NICE guideline CG9,

2004). Nonetheless, psychodynamic psychotherapy continues to be one of the most commonly offered treatments for eating disorders across both adolescent and adult settings since the first psychological models of eating disorders were constructed with a psychodynamic underpinning (Brunch, 1962; Hartman 1958; Kay & Leigh, 1964). Traditionally, Psychodynamic Psychotherapies have been resistant to the rigorously evaluated research trials more commonly seen in Cognitive Behavioural Therapy, with practitioners preferring smaller, case-study approaches to illustrate efficacy (Fonagy, 2015); however this has been slowly changing, with an increasing number of studies attempting to evaluate the efficacy of psychodynamic psychotherapy in comparison to other treatment options (Abbass, Hancock, Henderson & Kisely, 2006; Fonagy, 2015; Leichsenring, Rabung & Leibing, 2004). As such, there is an emerging body of evidence to suggest that psychodynamic psychotherapy is an effective psychological treatment for eating disorders (Dare, Eisler, Russell, Treasure & Dodge, 2001; Treasure, Todd, Brolly, Tiller, Nehmed & Denman, 1995; Wild et al, 2009).

2.4 Transference and Countertransference

Transference and countertransference are two of the central tenets of psychodynamic psychotherapy. Transference can be defined as thoughts, feelings and behaviours which are originally experienced during childhood in relation to others (often caregivers), which are then displaced onto someone else later in life (Moore & Fine, 1990). Most commonly, this occurs within therapeutic relationships. Conversely, countertransference has been somewhat redefined over the years, with a split in the way that different schools of thought think of this. The more 'narrow' definition utilised by Freud (1910) and his fellow 'classicists' define countertransference as the unconscious responses of the therapist to the

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transference of the patient (Freud, 1910; Tosone, 1997). However, the 'broader' definition adopted by 'totalists' includes all reactions and feelings experienced by the therapist (both conscious and unconscious) in response to both the patient's transference and the patient's needs (Racker, 1968).

The importance of transferential and countertransferential reactions cannot be underestimated, as it is thought that these reactions give insight into the patient's early relational experiences, as well as their current internal world (Racker, 1968; Winnicott, 1949). However, it has also been long acknowledged that transference and countertransference reactions can significantly impact both the therapist and the therapeutic relationship. For example, Searles (1987) noted that patients with borderline presentations may make extreme demands on their therapist. Without proper analysis and containment of the transference and countertransference, the therapist may become lost or react inappropriately. Similarly, Racker (1957) argues that unexamined or unidentified countertransference reactions can often result in therapists 'retaliating' to their patient, while Epstein (1987) highlighted how therapists can be left with negative ideas of their own abilities, resulting in what Epstein (1987) termed the "bad-analyst feeling". Furthermore, it is common for therapists to experience hate (Maltsberger & Buie, 1974), hopelessness (Richards, 2000), ambivalence (Jackson, 1983), and even vicarious traumatisation (Pearlman & Saakvitne, 1995), all of which can lead to the breakdown of the therapeutic relationship if not properly contained (Maltsberger & Buie, 1974). Furthermore, it has been suggested that it is the overall severity of psychopathology or the clusters of personality traits which result in the most dysfunctional countertransferences (Colson, Allen, Hamburg & Herzog, 1990), with more complex and severe presentations or those which are riskier resulting in the most intensely distressing countertransferences (Kleespies & Dettmer, 2000). A previous review

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conducted by Golan, Yaroslavski and Stein (2009) looked specifically at the psychodynamic perspectives on the development of eating disorders, and how these early experiences may contribute to transference and countertransference reactions which may be experienced by staff. The review concluded that the early interruptions, ruptures, and failure to internalise 'good objects' experienced in caregiving relationships (which are theorised to be behind the development of eating disorders in psychodynamic and psychoanalytic theory) result in the complex pattern of behaviour seen in those with eating disorders. The countertransference, therefore, is thought to be reflective of the internal reality of those with eating disorders (Golan et al., 2009).

2.5 Focus on countertransference

The decision was taken to focus the review on the idea of 'countertransference' rather than focusing more generally on the impact of eating disorder settings, as it the impact of work on the self is a central tenet of psychodynamic and psychoanalytic thinking. This pre-existing emphasis on 'countertransference' often result in clinicians being extremely attuned to and aware of the impact that their work may have on themselves, resulting in a higher number of publications focusing on the impact of work environments on clinicians themselves.

Conversely, other theoretical frameworks (such as Cognitive Behavioural Therapy) have traditionally not encouraged clinicians to focus on their own experiences while in the room with clients, preferring to think about client experiences, mechanisms of change, or theoretical techniques. Therefore, there is no established terminology for the impact that work may have on the self within these theoretical frameworks. Preliminary literature searches into the area of changes experienced by clinicians were conducted to establish a

list of key words, which supported the idea that almost all pre-existing research into this area was framed using the concepts of countertransference.

2.6 Aims of the review

Those with eating disorders are at greater risk of mortality (Steinhausen, 2002) and suicidality (Arcelus et al., 2011; Harris & Barraclough, 1998). They are more likely to be resistant to treatment (Williamson et al., 1999; Vitousek et al., 1998) and to have high levels of co-morbidity, including anxiety disorders, depression, personality disorders, and post-traumatic stress disorders (Braun, Sunday & Halmi, 1994; Blinder, Cumella & Sanathara, 2006). Additionally, societal ideas around 'thinness' and 'fatness' are likely to reinforce the pursuit of weight loss typically seen in anorexia, giving eating disorders an aspect of social acceptability unseen in other diagnosable mental health disorders (Bloom et al., 1994; Bloom, 2002). Therefore, it seems plausible that clinicians working within eating disorder settings may be subject to some of the most personally difficult and distressing countertransference reactions. However, the previous review conducted by Golan et al. (2009) was composed mostly of theoretical papers and book chapters, resulting in more of a conceptual review, which focused on how the theoretical processes underpinning eating disorders may contribute to transference and countertransference. No assessment of quality was used, and there was no discussion of the research base currently available. Therefore, although this review is helpful as a conceptual review of the psychodynamic theory of eating disorders, it had limited application to the evidence base of how staff may be affected by countertransference. As such, the aim of this review is to assess and analyse the existing research literature pertaining to countertransference reactions experienced by

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clinicians working with patients experiencing eating disorders. For this purpose, the broader, totalist definition of countertransference employed by Racker (1968) will be used.

3. METHODOLOGY

3.1 Search

A preliminary search was performed, followed by a full search using the following terms:

((Eating Disorder) OR Anorexi* OR Bulimi*) AND ((Counter transference) OR countertransference)

As the term countertransference and counter transference is used interchangeably in literature, both terms were included. The Boolean operator 'AND' was used to combine unrelated word/subject areas, the Boolean operator 'OR' was used to ensure that articles using different eating disorders were included, and the truncate symbol (*) was used to ensure that all possible alternative terms (e.g. anorexia, anorexia nervosa, anorexic, etc.) were included. The search was performed using PsychInfo, Medline, PsychArticles, Social Policy and Practice, and the Canterbury Christ Church University Library Search. Google Scholar was also checked to ensure that no studies had been missed. The search was conducted between August and November 2016. The field search option was used in Ovid (used to search all of the above with the exclusion of the Salomons Library Search and Google Scholar) to limit the number of irrelevant results returned. Following the search, a manual search of all relevant articles identified was then conducted to identify other articles of potential relevance. Searches were limited to journal articles. No date range was used due to the relatively recent nature of most research papers in this area.

The titles of all search results were initially screened for relevance. Potentially relevant or ambiguous results were then considered based on their abstracts, with full-text versions of

articles being obtained for more in-depth consideration of relevance. A flow diagram depicting the searching and screening process can be found in Figure 1. Sixteen relevant studies were identified, which will form the basis of this review – see Table 1 for a full list of all studies reviewed with main discussion points.

3.2 Inclusion and exclusion criteria

To be included within this review, studies must have focused, at least in part, on the specific countertransference experienced by clinicians working with eating disorder patients, and the subsequent effect that these countertransferences had either on the clinician or on the therapeutic relationship. Single case studies and theoretical papers which included case material were included, as psychodynamic literature has previously favoured this method of dissemination.

Articles were excluded if any of the following criteria were met:

- The articles were not in English
- The articles did not mention countertransference processes at all
- The papers discussed countertransference processes in relation to other diagnostic categories with no mention of eating disorders.
- Papers were purely theoretical in nature, with no clinical material or case studies presented.
- The articles focused on countertransference in relation to Binge Eating Disorder. As previously highlighted, it is thought that the mechanism underlying Binge Eating Disorder may differ to those underlying Anorexia and Bulimia. Additionally the distorted perceptions of the self and the social reinforcement of the illness are not

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generally present in Binge Eating Disorder. Therefore the countertransference may differ.

- Books were excluded as they were beyond the scope of this review.

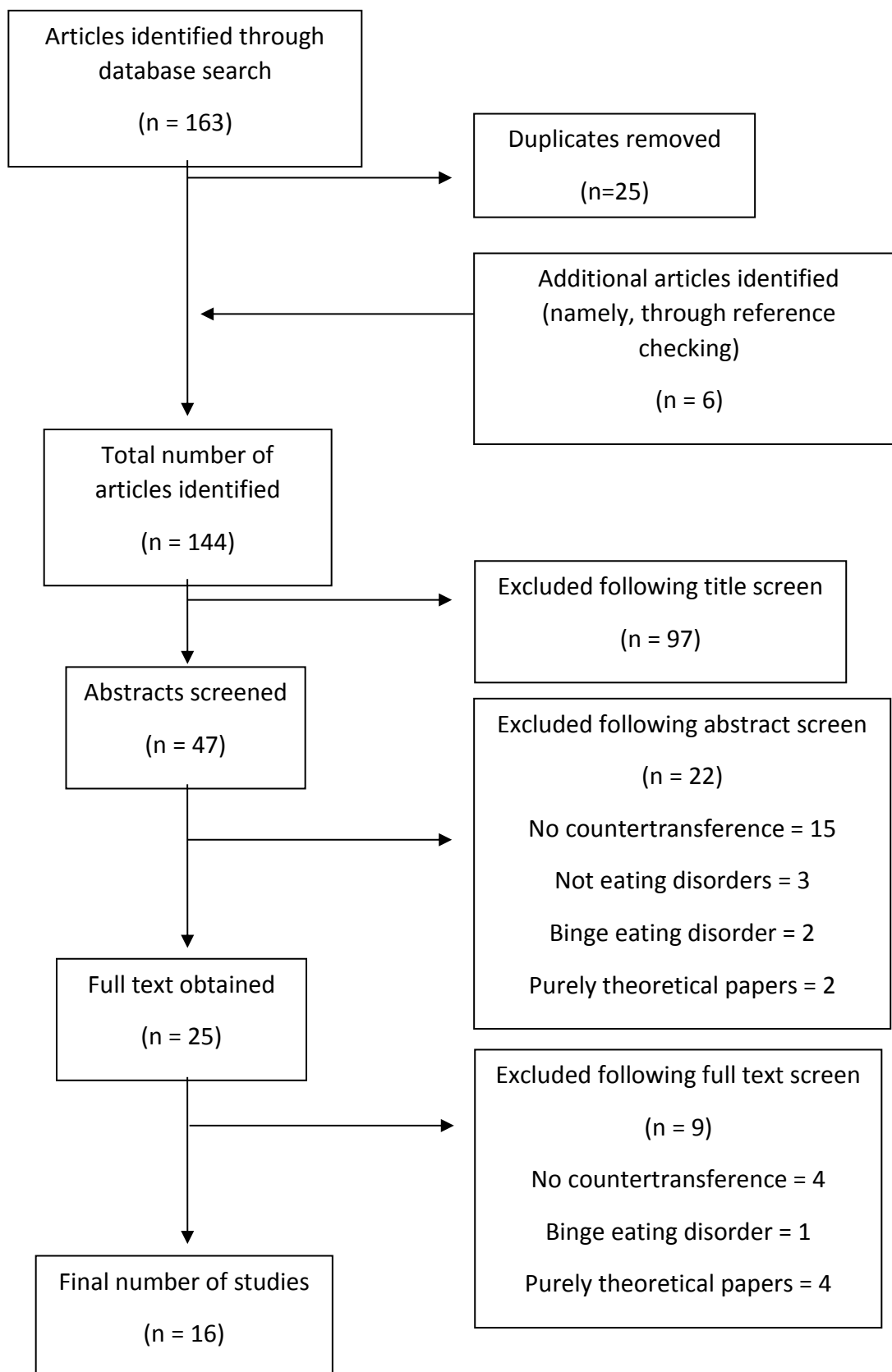
Figure 1 – Flow chart showing full search results

Table 1: Overview of papers included and main discussion points

Study number	Author	Design	Sample	Summary of paper
1	Conrad, N., Sloan, S. & Jedwabny, J. (1992)	Team case study	Staff working on inpatient unit. Number not specified.	Power struggles and issues of control noticed on inpatient unit, believed to be re-enactment of patient's experiences with family. Discusses steps taken by the team to address.
2	Daly, S. (2016)	Single case study	N=1	The therapist's own body can elicit feelings of envy and anger in patient, but can also be used to bring these feelings into therapeutic discussions.
3	Derenne, J. (2006)	Case study of own experience	N=1	Therapist began experiencing own body image issues and noticed increase in self-consciousness. Discussed similarities with patient's own experiences.
4	Franko, D. & Rolfe, S. (1996)	Mixed quantitative and qualitative survey	N=32	Asked clinicians to rate countertransference reactions to last patient seen with AN, BN and depression on 34 emotional subscales. Collapsed emotional reactions to give nine subscales. Found that 5 of 9 subscales differentiated patient group. Size of caseload and amount of experience affected extent of countertransference reactions. Factors felt to help with difficult countertransference reactions discussed.
5	Hudson, I. & Ritchie, S. (1999)	Group case study	Clinical material from group psychotherapy – number not specified.	Discussed countertransferences noticed by group facilitators, highlighting that these were reflections of group process occurring.
6	Hughes, P. (1997)	Case study	Clinical material of four patients presented	Patient may evoke a number of reactions in those around them due to wish to destroy/damage self.
7	Lowell, M. A. & Meader, L. L. (2005)	Case study	Two case studies presented	Discusses countertransference issues arising during therapy where the therapist is noticeably 'thin'. Uses case study of an underweight woman

with Anorexia and an overweight woman with Bulimia Nervosa to illustrate differences in countertransference.

Study number	Author	Design	Sample	Summary of paper
8	Palmer, A. (2015)	Qualitative interviews	N=5 dance/movement therapists	Countertransference common. Emotional and physical reactions noticed by therapists. Ways to manage countertransference discussed.
9	Rose, S. (2009)	Single case study	N=1	Presented countertransference experienced in therapy with client. Described process of other professionals unknowingly colluding with threat of breakdown to therapy.
10	Satir, D., Thompson-Brenner, H., Boisseau, C & Crisafulli, M. (2009)	Quantitative study using questionnaires	N=120 Surveyed multidisciplinary clinicians.	Study researching common countertransference reactions. Six patterns identified. Level of negative reactions low, but gender and job role of clinician, diagnosis of patient, length of time in treatment and personality pathology associated with different patterns of countertransference.
11	Shisslak, C., Gray, N. & Crago, M. (1989).	Quantitative study using questionnaires	N=71 Multidisciplinary clinicians surveyed.	Participants were classified into one of three groups based on their eating. Interactions found between previous history of eating and emotional reactions to working in eating disorder setting.
12	Strober, M. (2004)	Case study	Three case studies presented	Normality of experiencing negative countertransferences highlighted due to patient resistance to intervention. Importance of supervision and awareness of own characteristics discussed.
13	Swatton, A. (2011)	Single case study	N=1	Specific case study discussed. Attention paid to transference and countertransference reactions, with result being that nurse's ability to reason and responsiveness to psychological factors was compromised. Importance of medical professionals being aware of processes highlighted.
14	Vlahaki, I. (2012)	Single case study	N=1	Discussed somatic countertransference, which re-enacted patients own physical experiences of both bingeing/purging and her relationship with mother. Discussed using reactions to move therapy forward.

15	Walker, S. & Lloyd, C. (2011)	Qualitative interviews with study group	N=15 Participants had to hold professional qualification	Found negative countertransferences were common amongst professionals. Highlights inpatient settings and lack of training may result in particularly difficult countertransference experiences.
16	Warren, C., Crowly, M., Olivardia, R. & Schoen, A. (2009)	Mixed qualitative and quantitative study	N=43	Patients commenting on clinician appearance common. 70% felt personal views on food had changed, 54% thought eating had changed, & 71% felt awareness of appearance had increased. Importance of supervision highlighted.

4. Review

4.1 Description of papers

4.1.1 Overview

Five of the papers (2, 6, 9, 12 and 13) focused on clinicians working with patients with Anorexia, while three (5, 7 and 14) focused on those working with Bulimia. Two papers (4, 10) referred to clinicians working with different diagnoses, and six studies (1, 3, 8, 11, 15 and 16) did not specify which diagnoses clinicians worked with; however, all of these studies utilised clinicians working either in inpatient settings or made reference to clinicians working with patients with very low body weights. Nine of the papers (2, 3, 6, 7, 8, 9, 12, 13, 14) discussed the countertransference experienced by single therapists engaging in sessions with patients. Of these therapists, six were psychodynamically oriented therapists engaged in one to one therapy (2, 6, 7, 9, 12, 14), one (13) was a nurse seeing a patient for physical treatment, and one (3) was a junior doctor seeing patients for individual sessions as part of their psychiatry rotation. Two papers (5, 8) discussed the countertransference experienced by groups of clinicians made up of a singular profession – one (5) referred to two psychodynamically oriented therapists facilitating group therapy, while the other (8) looked at the experiences of dance/movement therapists. Finally, six papers (1, 4, 10, 11, 15, 16) discussed the experiences of multiple clinicians across a range of disciplines.

4.1.2 Design

Nine of the papers used qualitative methods. Of these, eight of the papers used single case studies (2, 3, 6, 7, 9, 12, 13, 14), one (1) used a team case study, one (5) provided a case study of a group process, and two (10, 11) used qualitative analysis on group responses to a study question. One (16) used a mixed methods approach and three (4, 10, 11) used quantitative research methods. Of those that used quantitative methods, all three used questionnaires to establish correlations.

4.2 Quality of studies

Three main types of study were used: qualitative (including case studies), non-randomised correlational quantitative and mixed-methods research. Therefore, the quality analysis tool developed by the National Collaborating Centre for Methods and Tools (2015) was used to assess the quality of papers presented, as this tool contains checklists for qualitative (including case study designs), quantitative and mixed methodologies (see Appendix A). Although this checklist does not result in absolute ratings of 'good' or 'bad' quality, the checklists contain several different questions for consideration which qualitatively indicate a study of a higher quality (such as consideration of data analysis, sampling strategies, response/follow up rates, dropout rates, etc.). Therefore, all studies used were compared to these checklists; however, a qualitatively poorer rating did not result in studies being excluded from the review, although aspects of studies which do not meet the criteria in the checklists have been noted. Due to differences in strengths and weaknesses and for clarity, the papers using case study designs and those using qualitative methods on groups of clinicians will be separated out.

4.2.1 Case studies

Strengths

Due to the focus on countertransference processes, all papers using case study designs (1, 2, 3, 5, 6, 7, 9, 12, 13, 14) studies gave proper, in-depth consideration as to how interactions with or the influence of the therapist/researcher may have influenced outcomes. Additionally, all case study designs gave sufficient consideration to the context in which the case study was taking place, highlighting the unique challenges of one-to-one sessions with patients experiencing eating disorders. It was felt as though the sources of information (i.e. the processes engaged in and material discussed during

therapy) were relevant to addressing the objectives/research questions of the papers – that is, the countertransference experienced by the therapist in question.

Weaknesses

One of the main weaknesses inherent in case study designs is that all findings are applicable only to the specific therapist with the specific patient described. No larger conclusions can be drawn about commonalities in processes experienced by therapists on the bases of case studies taken in isolation. Therefore, when considered independently, the generalisability of the case study designs are weak; however, repeated case studies by different clinicians describing the same countertransferences may begin to create a picture of commonality required to justify more in-depth research. Furthermore, most of the case studies in question were written by psychodynamically oriented psychotherapists engaging on one-to-one sessions with patients (2, 6, 7, 9, 12, 14), which represents a very limited sample.

Additionally, there is limited description as to how data has been analysed in all case study designs presented. There is no mention of process notes, outcomes, tapings of sessions and so on – only sections of material and the interpretation of these. Therefore, the reliability and validity of material discussed cannot be effectively evaluated.

4.2.2 Qualitative studies

Strengths

Both of the papers (8, 15) used interviews to gather the views of clinicians working with clients diagnosed with eating disorders – one of the papers (8) conducted individual interviews, while the other (15) used a focus group. Both papers clearly stated that interviews were audiotaped and gave an overview of the questions/topic areas discussed with individuals taking part in the studies. One paper

(8) talked extensively about the process of validation, including the use of epochè (that is, the separating off of researchers own opinions). Both papers thoroughly described the process of analysis, including the pre-established procedural stages for data analysis utilised. Both papers gave some consideration to the impact that the researcher may have had on the results of the interviews.

Weaknesses

Neither paper gave consideration as to why participants may have been motivated to take part in the interview process, or why participants may have declined to be included. One paper (15) discussed the sampling technique used, highlighting that all participants were recruited from the same hospital. Therefore generalisability to other settings may be limited. Additionally, one of the papers (8) used a relatively small sample of five participants, all of who were from the same professional background of dance/movement therapists. This may mean that the ability to extrapolate the experience of this professional group to other clinicians is limited.

4.2.3 Quantitative studies

Strengths

All of the studies (4, 10, 11) used questionnaires to establish the correlation between clinicians working with patients with eating disorders and emotional responses/experiences. All of the studies gave an overview of the sampling strategy used, which was appropriate for the question, with two of the studies (4, 11) including clinicians from a variety of professional backgrounds. Two papers (10, 11) explicitly stated that research was exploratory; therefore, the methods employed were thought to be appropriate. The completion rate for one study (10) was satisfactory, with a completion rate of 65%. Additionally, both studies (4, 10) requesting that clinicians think about their reactions in relation to patients attempted to ensure the random selection clinical material by requesting that clinicians use

the last patient seen who meets the specified diagnostic criteria. This was an attempt to control for selection bias that may have been present otherwise – for example, to stop clinicians from choosing a preferred patient, or a particularly problematic patient.

Weaknesses

Two of the studies (4, 11) had a low completion rate, with only 46% and 41% of clinicians respectively completing and returning the questionnaire. Although both studies state that this is within normal parameters of previous studies, this is still low according to the checklist employed. Additionally, one of the studies (10) used a relatively limited sample of only psychiatrists and psychologists, while the other study (11) recruited participants from those attending a conference on eating disorders. This may mean that key members of the multi-disciplinary team who may be less likely to attend conferences (e.g. health care assistants/support workers) may have been missed. The final study (4) recruited participants who had identified themselves as being 'experts' in the area of eating disorders, which may indicate that once again, those clinicians such as health care assistants may have been excluded from research. Additionally, by recruiting from a pool of those classifying themselves as 'experts', the representativeness of the sample may have been compromised.

Furthermore, as all studies were exploratory in nature, they all used self-developed questionnaires which had not been tested for validity or reliability. This was somewhat unavoidable given the paucity of research in this area; however, the lack of rigorous testing of questionnaire material may result in the reliability of results being somewhat limited. This is especially true when considering that two of the studies sought to generate a scale of reactions experienced (4, 10) while the other categorised participants based on their eating habits (11). These categorical dimensions were not subject to rigorous analysis, and therefore must be considered with caution. Finally, one of the studies (4) stated that some respondents did not complete all scales – however the number of incomplete scales

received was not reported and no consideration was given as to why respondents may or may not have omitted some scales. Therefore there may be some confounding variables which were not fully considered or controlled for present within this study. Finally, in asking therapists to think of the last patient seen (4, 10) rather than asking clinicians to think more broadly about the general reactions experience, the conclusions drawn may only be relevant to that particular patient, rather than being indicative of broader countertransference processes.

4.2.4 Mixed method approaches

Strengths

The study employing a mixed methods approach (16) was clear as to the rationale in using a mixed qualitative and quantitative approach, with the methods selected being suitable to answer the research question. The data was brought together in a coherent analysis, with the researcher and two others coding the qualitative data independently before meeting to check the congruence of codes.

Weaknesses

Although the data was integrated coherently, there was no mention of when this integration occurred. Additionally, no consideration was given to the limitations of the mixed methods approach. Furthermore, all participants were once again attendees at an eating disorder conference, with all holding professional qualifications. Once more this induces a confounding variable, in that the subject pool consisted entirely of those motivated and able to attend a conference. No health care assistants/support workers took part in this research, and only a very small proportion of nurses were present in the sample.

4.3 Countertransference in staff working in eating disorder settings

4.3.1 Emotional Countertransference

Eleven of the papers discussed the emotional effect that working with patients with eating disorders had on clinicians (1, 4, 5, 6, 8, 9, 10, 12, 13, 14, 15), with all of these papers noting at that at least some negative emotional countertransference was common. Two papers (5, 14) spoke about therapists feeling in some way ‘controlled’, with one (5) highlighting how therapists may feel as though they cannot give enough or, conversely, what they are providing is wrong. Additionally, therapists may feel marginalised (5) or may feel as though the patient is in charge (14).

Anger was a common reaction, noted by six of the papers (5, 6, 8, 10, 12, 15). One paper (5) discussed the ways in which behaviour perceived as coercive may result in the pull to give ‘special treatment’. Subsequent resistance to treatment was thought to be the reason for resulting anger (5), while this coercive behaviour and subsequent rejection of care could often lead to power struggles between patients and their therapists (1). Frustration (4, 8, 10, 12, 15), concern (6, 8), envy/competitiveness (5, 13) and responsibility (5, 13) were all commonly noted and discussed. Additionally, two papers (9, 10) discussed how feelings of boredom were common, noting that this may be a reflection of the detachment that patients feel towards therapy and potentially to emotional states in general (9). Finally, two papers (4, 10) specifically discussed feelings of ‘caring/connectedness’; however, both papers noted that these ‘warm’ feelings could be reduced when the behaviour of patients and the negative countertransferences experienced by staff became more intense. These difficult experiences were summed up by one paper (12), which noted that negative countertransferences were commonplace amongst therapists working in eating disorder settings, and can often result in the desire to be ‘free’ from the client.

4.3.2 Physical countertransference

Two papers specifically discussed the physical countertransferences experienced by therapists (8, 14). One paper (8) spoke extensively about physical sensations of anxiety, which commonly mirror the experiences of the patients being treated for eating disorders. Additionally, discomfort and tension within the therapist's body and a strange sensation of 'fluttering' in the chest were reported by the dance/movement therapists interviewed (8). The other paper (14) highlighted how the therapist in question began to feel 'riveted' on their own bodily reaction in a similar manner to which the patient was fixated on their own bodily reactions. The therapist noted that sessions often left him with a feeling of being 'force-fed' and 'uncomfortable full', which were reflected on given that the patient in question was one being treated for Bulimia Nervosa.

4.3.3 Impact on clinician's perception of their body

In total, six of the papers discussed the impact that working with patients with eating disorders had on clinician perceptions on their bodies (2, 3, 7, 11, 15, 16). Body image issues (3), including clinicians feeling more aware of their bodies (2, 11, 15, 16), feeling more self conscious (2, 3, 7, 11, 15), increasing exercise (3), and experiencing bodily distortions (7) were all noted. Two papers (2, 16) discussed the feeling of 'being watched' by patients, almost as if patients were monitoring or evaluating the bodies of staff, which may contribute to the increase in feelings of 'self-consciousness'. Indeed, one paper (16) specifically asked clinicians whether their patients ever commented on their (clinician's) bodies. Not only did clinicians generally agree that this was common, but they highlighted that approximately twenty five percent of their patients had made a comment about their (clinician's) appearance. Although the majority of these comments were perceived as compliments (86%), thirteen percent of comments were regarded as criticisms, with the vast majority of these being due to the weight, height or age of the clinician. Additionally, two papers (11, 16) noted that clinicians felt as though they were more aware of the food that they were eating, with one paper (16) specifically

stating that clinicians surveyed felt as though their eating habits had changed. One paper (16) noted that twenty five percent felt as though they were engaging in more disordered eating since working in eating disorder settings, with seven percent noting that they had engaged in disordered eating behaviour immediately after a session. However, that is not to say that all of these reactions were negative. Although feelings of shame (7, 15) were noted, several of the papers highlighted that these perceived changes may have been positive (7, 11 15), with a particular emphasis on the fact that many clinicians felt as though they were eating healthier as a result of their work with patients with eating disorders (11). Additionally, one paper (2) noted that the impact that working in eating disorder setting may have on the clinician's perception of their body may differ due to their own pre-existing perceptions of self, as well as how 'desired' their body type may be by the client group. 'Thin' therapists may be more likely to feel pride than disgust at their own bodies (2), which may mediate the intensity of negative changes to their perception of their own bodies and eating habits.

4.3.4 Countertransference and the impact on team processes

One paper looked specifically at the impact that countertransference had on the dynamics of the team (1). On arrival at the inpatient service, the author noted that staff and patients both seemed 'out of control'. Power struggles between patients and their eating disorders, as well as patients and staff, were mirrored in power struggles between different members of staff – most commonly, between different disciplines of staff, such as nurses and the psychiatrists. Additionally, 'splits' within the staff team were relatively commonplace, which seemed to make treatment of patients more difficult due to conflicts and difficulty finding a consensus around the best course of treatment.

4.3.5 Difference in countertransference and diagnosis

Two papers (4, 10) looked specifically at the impact that different diagnoses may have on the countertransference experienced by clinicians working with patients with eating disorders. The first paper (4) found that those with a diagnosis of Anorexia Nervosa elicited more feelings of frustration and hopelessness and fewer feelings of connectedness and successfulness than those with a diagnosis of Bulimia Nervosa. However, feelings of engagement were similar in clinicians working with patients with Anorexia Nervosa and Bulimia Nervosa. Interestingly, these were mediated by caseload size and the level of experience that clinicians had (both general level of experience as therapists and experience specifically within eating disorder settings), with a larger case load and less experience associated with more negative countertransferences. Conversely, the other paper in question (10) asked clinicians about working with those with a diagnosis of Anorexia Nervosa, Bulimia Nervosa or Eating Disorder Not Otherwise Specified (EDNOS), finding that Anorexia was associated with more feelings of warmth/competence than the other two diagnoses and fewer feelings of failing/incompetence than EDNOS. However, the paper highlighted that personality pathology (i.e. a pattern of interaction consistent with a diagnostic label of personality disorder) may mediate this, with significant personality pathology associated with increased feelings of anger/ frustration and fewer feelings of warmth/competence.

4.3.6 Management of countertransference reactions

In total, nine of the papers (1, 3, 4, 6, 8, 12, 13, 15, 16) suggested ways in which countertransference could be managed. The importance of supervision was particularly highlighted (8, 12, 16), with one paper (12) in particular stressing the importance of supervision being a place for 'emotional discharge'. Three papers (6, 8, 13) highlighted the need for clinicians to remain aware of their feelings 'in the moment' and to be able to name the difficult reactions that they may experience. Although this may be manageable and relatively easy for therapists trained in psychodynamic or psychoanalytic therapy,

other members within the team who may not have this theoretical grounding may find this problematic (13). Therefore, it is important that *all* team members are encouraged to pay attention to countertransference processes, including those who may be working from a more medically oriented model (13). One paper (15) stressed how inpatient setting may be especially problematic, due to the more intense resistance typically exhibited by patients coupled with the effects that starvation have on the brain (15). Where this begins to impact the whole team and factors such as splitting, power conflicts or lack of control become more noticeable, implementation of clear expectations, guidelines and boundaries may be helpful in regaining balance and control (1). Lack of training (15) and inexperience (4) were also highlighted as common reasons for clinicians experiencing particularly negative countertransference. Smaller caseloads, particularly for staff with less experience working with eating disorders and in general (4), were correlated with significantly fewer countertransference reactions. Additionally, investment in training for staff at all levels (15) was seen as important by staff surveyed in helping to manage negative reactions. Finally, general awareness of the self, including pre-existing body image issues (2, 15), personality characteristics (12), and ability to remain compassionate towards the self in the context of difficult experiences (8) were seen to be important qualities for staff to analyse and embrace, either independently or in supervision (8).

5. DISCUSSION

5.1 Summary of findings

Generally speaking, there is a paucity of literature into the impact that countertransference has on staff working in eating disorder settings. The few articles which do exist are generally poorer quality – they primarily focus on therapists, with single case studies seemingly written in retrospect the most common method of disseminating ideas and results. Those which have sought to establish common countertransference using groups of participants, either qualitatively or quantitatively, have relied

heavily on questionnaires, or have generally recruited from potentially homogenous sources. However, despite the relatively poor quality of many of the papers, the majority of published research has highlighted that staff may be deeply affected when working with patients with eating disorders. Many of the experiences are negative, with anger, frustration, increased self-consciousness, conflict within teams and physical discomfort all being reported. In particular, staff who are relatively inexperienced or those who lack training appear to report the most significantly distressing and difficult countertransference reactions, with high case loads being linked to more intense countertransference. There is some preliminary evidence that diagnosis may be linked to differences in countertransference; however this research is extremely limited and conflicting. Generally, there are similarities in the suggestions as to how best to manage difficult and intense reactions, with supervision seemingly the most commonly cited suggestion. Being encouraged to be aware of emotional reactions, the space to consider what these reactions mean and the vocabulary to name countertransference may all help clinicians understand and manage what may be intense and potentially very personally distressing experiences. However, it is important to note that not all of the reactions experienced by clinicians are negative, with some suggestions that working in eating disorder settings resulted in healthier food choices, increased activity and even some pride about body image.

5.2 Implications for clinical practice

Despite the paucity of research, there does appear to be a general consensus that working with patients with eating disorders can result in clinicians experiencing a number of negative reactions emotionally, physically, and with regards to their body image. This may have an impact on treatment; clinicians who experience anger, envy, frustration and inadequacy in relation to their patients may find it harder to build a therapeutic relationship and to engage meaningfully with the patients who elicit the strongest countertransference. Clinicians feeling as though their bodies are under scrutiny, or

those who receive direct comments about their appearance, may become more aware of their bodies which may in itself result in increased negative feelings towards their patients. Additionally, there is a possibility that staff retention may be affected, as it is plausible that staff may be reluctant to remain in an environment in which they experience a high degree of negative emotions while simultaneously attempting to treat patients who are ambivalent, resistant to treatment and negative about input received (Vitousek, Watson & Wilson, 1998; Williamson, Muller, Reas & Thaw, 1999). Indeed, previous research has highlighted that being overweight was a particular risk factor for burnout when working in eating disorder settings (Warren, Schafer, Crowley & Olivardia, 2013), implying that there is some substance to the idea that clinicians may experience an increase in self consciousness in relation to their bodies.

High case loads were also implicated in an increase in negative countertransference. Although theoretically having a higher ratio of clinicians to patients to keep caseloads low seems like a logical idea given the emotional intensity involved in working with patients with eating disorders, there are questions as to how realistic this is in the current climate of reduced funding and increased pressure to make efficiency savings which is characteristic of the NHS. Although the government announced an extra one hundred and fifty million pounds would be directed towards eating disorder services over the next five years (Autumn Statement, 2014), this comes with specific waiting list targets of assessment within four weeks of referral, which is likely to mean increased pressure on clinicians to assess and treat as many patients as possible in a short time frame.

Although inpatient services were highlighted as being particularly difficult in terms of the negative impact on staff, this seems somewhat logical due to the inference that those requiring inpatient admissions are more at risk physically from their eating disorder, which may also imply that their eating disorder is more established or severe in pathology (having lost enough weight that they are

physically compromised). Therefore, staff working in inpatient settings may find countertransference particularly problematic. However, co-morbidity of other complex mental health conditions, including suicidal ideation and self-harm (Braun, Sunday & Halmi, 1994; Harris & Barraclough, 1998), coupled with the need for round-the-clock supervision of patients may result in increased time constraints, which are often inherent with working on an inpatient ward. Therefore, finding time to adequately analyse and consider the countertransference of staff may be problematic, resulting in a need that goes broadly unmet. The same could be said for finding adequate time for good supervision, which was consistently flagged as being one of the ways to understand and process negative countertransference. Previous research has suggested that supervision within an inpatient setting may be sparse, and when analysed, meetings classed as clinical supervision often do not meet the criteria of supervision (Cleary & Freeman, 2005). As such, one of arguably the most important processes in which staff are supported to manage their difficult experiences may often be missing or inadequate in inpatient settings.

5.3 Implications for research

Research into the ways in which staff may be impacted by their work in eating disorders is still a relatively new field, with a paucity of studies. Those studies which have been conducted are of generally poor quality, using small samples of limited professional groups or relying on single case studies. Despite the fact that studies have generally tended to find similar countertransference reactions in clinicians, the ability to generalise these findings is still extremely limited. Therefore, further good quality research is needed in general to begin to establish a fuller picture of how countertransference may impact staff working with those with eating disorders. Additionally, while the focus on purely descriptive processes is necessary for research at its genesis, it leaves little room for

inference as to *why* these processes may be occurring. Although we may be able to call these influences ‘countertransference’, this is simply a technical term generated from one school of psychological theory, and it may be a term that is only understandable to those who have some knowledge of psychodynamic or psychoanalytic processes. Therefore, this terminology may be of limited use to other members of the multidisciplinary team who have not had this grounding, and it may be useful to explore exactly how staff make senses of these experiences. Indeed, previous research has focused almost exclusively on therapists and psychiatrists, who are the most likely to have some theoretical knowledge about countertransference and may be comfortable talking about the impact in these terms. However, other members of the team without this grounding may find this terminology confusing or unclear. Therefore, if other members of the team are included in future research, broadening out the terminology so that it may be understood and embraced by all members of the clinical team may be helpful. An additional problem with this limited subject pool is the fact that therapists and psychiatrists may be the clinicians who have the most awareness of countertransference processes. This awareness may be protective, as it may allow clinicians to label experiences (especially those which may be experienced as negative) as being a by-product of therapeutic processes rather than being generated through internal changes. However, those clinicians without this grounding may lack the ability to label these experiences as being due to countertransference, and therefore may find these experiences more personally distressing. Although there has been some inclusion of social workers in previous research, nurses have only been included in an extremely limited number of studies, and healthcare assistants or support workers have been excluded entirely. As a wide range of professionals are involved in the support, care and recovery of those with eating disorders, it seems strange that research has not reflected this. Future research may therefore wish to broaden inclusion criteria to assess the impact that countertransference has on a wider range of professionals, and whether there is a difference in the extent to which different

professionals are impacted by their work. Additionally, supervision has been suggested as a method to manage countertransference processes; however what supervision looks like may differ vastly between professional groups or between individuals (Cleary & Freeman, 2005). Future research may wish to focus specifically on the impact that supervision has on clinicians' ability to manage the impact of working in such an environment.

More broadly speaking, the vast majority of existing research uses the term 'countertransference' to discuss the impact that working within eating disorder services may have on staff. Generally, the established nature of the term countertransference within psychodynamic and psychoanalytic theory results in a distinct space for this research to sit, giving rise to consideration for how clinical work may impact clinicians which may otherwise go unconsidered or unpublished. This also had the added benefit of normalising difficult feelings and experiences for clinicians, thereby allowing consideration and discussion. However, the broadest definition of countertransference employed by totalists such as Racker (1968) suggests that it is a clinician's response to a patient's transference and needs, whether conscious or unconscious. Within this definition there is no consideration for other factors which may impact the clinician. Therefore, continuing to framing the impact of eating disorder work solely as 'countertransference' may restrict our understanding of these processes and why or how they occur to a singular, patient-driven explanation. A broader, more general consideration of how and why eating disorder environments may have such a significant impact on clinicians may therefore enable a broader consideration of these processes, resulting in a more comprehensive explanation.

There is some indication that inpatient working may have a more significant impact on clinicians than outpatient or community work, due to the complexity associated with individuals with eating disorders who require hospitalisation. An extension of this may be that more intense inpatient working – for example, in hospitals which use nasogastric tube feeding under restraint for those under involuntary

admission – may induce significantly more negative countertransference than working with those entering hospital voluntarily or those being treated within the community. Research may wish to look specifically at the ways in which different settings may intensify countertransference.

Finally, there is a growing body of evidence that working in an eating disorder setting may result in changes to clinicians' body image and eating habits, with some conflicting evidence as to whether these changes are perceived as harmful or helpful/healthy. This may have strong implications for the mental health and wellbeing of staff working in these settings – if the changes are indeed experienced as harmful, with clinicians experiencing increased bodily dissatisfaction and changes to their eating habits, then the ethical implications of staff working in intense environments without close monitoring, supervision, and discussion of the potential changes that they may experience become rather worrying. Further research is needed into whether these changes do occur, how staff may experience these, and what sense they may make of any noticeable changes.

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Section B: “Food for thought and thoughts of food”: A grounded theory analysis of the impact of inpatient eating disorder environments on staff body image and eating habits

Word count: 7994 + 290

7. Abstract

Objective: Research into how staff working in eating disorder setting may be affected by their work is still a reasonably new area, with many previous studies relying on homogenous groups for recruitment or utilising survey based methodologies. Therefore, this study used a grounded theory approach to construct a theory of changes to body image, perceptions of food and diet experienced by clinicians, how these changes are experienced or made sense of, and what factors may contribute to these changes.

Method: Thirteen members of staff were interviewed about their body image and eating habits before and since working in eating disorder settings. Participants were drawn from a range of different staff groups. Interviews were analysed using grounded theory to develop a theoretical model of why changes to body image and eating habits may occur.

Results: Three core categories were defined, and a theoretical model was postulated in which pre-existing body image and ideas of food, the work environment, access to support, the impact of patients themselves and promotion of chaotic eating through the work itself all interplay to create change. Individual differences in management and the “personalised meaning” ascribed to these changes mediate how these changes are labelled and managed. Implications for future research and clinical practice are discussed.

Key words: Eating Disorders, staff, countertransference, grounded theory, body image

8. Introduction

The concept of eating disorders is not a new one. Descriptions of eating disorders can be found as far back as the 12th and 13th century BC, with the earliest medical case studies being attributed to Richard Morton in 1689 (Pearce, 2004). However, it was not until 1873 with the publication of Gull's seminal case studies of Anorexia that the term 'Anorexia Nervosa' was coined (Gull, 1873). Since then, our knowledge of eating disorders has grown exponentially, with documented cases also multiplying in a similarly rapid way. However, despite a proliferation of research into understanding the theoretical biological, psychological and social factors which may contribute to an individual developing an eating disorder, research has only very recently begun to focus on how staff working with individuals diagnosed with eating disorders may be affected by their work.

Although understanding the impact that working with patients has on staff is a relatively new area of research in general, it is not a new concept in psychological theory. Indeed, one of the central tenets of psychoanalytic theory is that of countertransference, which was introduced by Freud in 1910 – that is, the influence that the patient has on the therapist due to the therapist's own unconscious feelings (Freud, 1910). This definition has been subject to some debate over the years, with Freud and his fellow 'classicists' favouring the original, narrower definition, while 'totalists' have tended to broaden this to encapsulate all of the reactions that the therapist may have towards the patient, whether conscious or unconscious (Racker, 1968). In any event, there have been multiple case studies throughout the years which have highlighted the impact that psychological therapy in general can have on the therapist – from the therapist experiencing hate (Maltzberger & Buie, 1974), to hopelessness (Richards, 2000) and even vicarious traumatisation (Pearlman & Saakvitne, 1995). Therapists can be left feeling inadequate (Epstein, 1987) or lost (Searles, 1987), and

countertransference that is improperly analysed or contained may result in the therapist acting inappropriately (Searles, 1987; Racker, 1957).

With so many accounts of the impact that countertransference may have on therapists, it is only natural that focus has shifted specifically to those working in eating disorder settings. There has been a growing recognition that recovery from an eating disorder does not often happen in isolation, with Goldberg (1986) positing that research had “ignored an extremely significant part of the process – the practitioner” (p. 25).

Generally speaking, research into this area has found many staff reactions which are similar to those which have been previously noted in relation to staff working with other mental health conditions, including anger (Hudson, & Ritchie, 1999), frustration (Franko, & Rolfe, 1996; Palmer, 2015), and inadequacy (Hudson, & Ritchie, 1999). Interestingly, however, there have also been many studies citing envy and competitiveness (Hudson, & Ritchie, 1999; Swatton, 2011), which remain relatively uncommon when studying staff reactions to working with patients with other diagnoses. One explanation for this is that western societal ideas strongly encourage ‘thinness’, equating it with ‘wealth’, ‘beauty’ and ‘success’.

Simultaneously, ‘fatness’ is discouraged, and often equated with being ‘unattractive’ and ‘lazy’. This lends a certain amount of social acceptability to eating disorders, with the boundary between being ‘desirably thin’ and ‘too thin’ being extremely blurred and moveable (Bloom et al 1994; Bloom 2002; Rodin, Silberstein & Striegel-Moore, 1985).

Additionally, the propensity for bodily comparisons (which may be self-to-self or self-to-other) often noted in those with eating disorders means that the body is often the subject of focus (Hamel, Zaitsoff, Taylor, Menna & Le Grange, 2012). Frankenburg (1984) noted that therapists’ bodies are often scrutinised by their clients, with clients often making comparisons between themselves and the therapist. Therapists have reported noticing this

scrutiny, with feelings of being 'watched' and 'evaluated' commonly described (Daly, 2012; Warren, Crowly, Olivardia & Schoen, 2009). In addition to just 'feeling' as though they are being watched, staff have also found themselves in the uncomfortable position of having their bodies directly commented on. In a survey of multidisciplinary staff working with clients with eating disorders, the majority of clinicians responded that patients had directly commented on their appearance (Warren et al., 2009). Roughly 20% of clinicians surveyed also noted that they had experienced difficulties within the therapeutic relationship, most notably around frustration with clients and managing countertransference. Warren et al. suggested that this increased scrutiny of the therapist's body and the ensuing countertransference experienced could potentially influence the way the therapist views their own eating and appearance (Warren et al., 2009).

However, research specifically into the ways in which clinician eating and appearance may be influenced by working with clients with eating disorder diagnoses has been extremely limited. Although there have been some reflective case studies which highlight the increased awareness that clinicians feel towards their own bodies (Daly, 2012; Derenne, 2006; Lowell & Meader, 2005), these studies are extremely limited in their generalisability. Overall, there is a general paucity of studies using larger samples of clinicians to draw overarching conclusions about the impact that eating disorder work may have on clinician body image and eating habits. Nonetheless, those studies which have used larger samples have resulted in somewhat conflicting results. For example, qualitative interviews with clinicians working in eating disorder settings revealed that clinicians often felt more aware of their body shape and size, and reported feeling 'huge' or 'big' when surrounded by 'tiny' and 'delicate' patients (Walker & Lloyd, 2011). These feelings of being 'larger' resulted in some of the clinicians feeling increasingly dissatisfied with their bodies, and resulted in the

idea that clinician confidence and bodily security were highly important for anyone working in eating disorder settings. Additionally, a theme to emerge from interviews was that previous poor body image experienced by clinicians could be 'awoken' through working in eating disorder settings.

Despite this, a similar finding linking previous body satisfaction to the extent to which clinicians notice changes to their body image and eating habits was noted in a study by Shisslak, Gray and Crago (1989). During this study, clinicians were surveyed, with a large proportion reporting increased awareness of food and their appearance, resulting in changes to body image and eating habits. This degree of change was linked to previous eating history ('normal', 'binging', or 'anorectic/binging with purging symptoms'), with those in the 'binging' or 'anorectic/binging with purging symptoms' categories reporting a greater awareness of food since working in eating disorder settings. Interestingly, clinicians reported that they felt as though these were generally positive changes, with the majority of those affected reporting that they felt as though they were now eating healthier food since beginning work in the field.

This potential to see changes to eating habits in a positive way was reflected in a further study using surveys by Warren et al. (2009). Seventy percent of clinicians reported feeling as though their eating perceptions of food had changed, while a 54% felt as though their actual eating habits had changed. Of those reporting changes, the majority felt as though they were positive changes, with participants feeling as though they were making healthier food choices, taking a greater enjoyment from eating food and eating more mindfully.

Conversely, twenty five percent felt as though they were engaging in more disordered eating since working in eating disorder settings, with seven percent noting that they had engaged in disordered eating behaviour immediately after a session.

Although these studies sought to explore whether clinicians were affected by their work in eating disorder settings, they did not consider how clinicians may make sense of these changes. Additionally, all of the aforementioned studies tended to use the psychoanalytic/psychodynamic view of 'countertransference' to explain the changes. As the term 'countertransference' is simply terminology from one school of psychological or psychotherapeutic theory, simply accepting and applying this term to the impact on clinicians may be rather narrowing, as it may only be understandable or considered by those who work in a psychodynamic or psychoanalytic way. Additionally, at its broadest definition, the term 'countertransference' considers only the reactions that a clinician may have in response to a patient's transference and needs (Racket, 1968). Other factors, such as the environment itself, clinician background and cultural ideals and pre-existing experiences of food/body image, may not be considered in this definition, leaving a much narrower (and potentially insufficient) explanation of why clinicians may be affected by their work.

Therefore, Swancott (2012) used Independent Phenomenological Analysis (IPA) to try to understand how clinical psychologists working in an eating disorder environment understood their eating and any changes to their eating habits. Although clinicians reported some behaviours that may be interpreted as being a result of working in an eating disorder environment (e.g. increased awareness of calorie content of food and vigorous exercise), clinicians generally reported feeling reasonably unaffected by their work. This resulted in the researcher concluding that clinicians may be consciously or unconsciously justifying or minimising changes to their perceptions of their body and food, emphasising the need for further research into this area.

Although there is some preliminary evidence to suggest that clinicians may experience changes to their body image and eating habits after beginning to work in eating disorder

settings, it remains unclear whether these changes may be experienced as positive or negative by the individual. Studies have tended to be of relatively poor quality, using homogenous samples which are restricted to those holding professional qualifications (Shisslak et al., 1989; Warren et al., 2009; Walker & Lloyd, 2011), those attending a professional-level conference (Shisslak et al., 1989; Warren et al., 2009; Swancott, 2012), a single hospital team (Walker & Lloyd, 2011), or a single professional group (Swancott, 2012), with the result being that all existing studies have utilised extremely homogenous groups which have excluded entire job roles, such as healthcare assistants/support workers. Existing studies have heavily relied on single case designs (Daly, 2012; Derenne, 2006; Lowell & Meader, 2005) or on surveys (Shisslak et al, 1989; Warren et al, 2009), both of which limit the generalisability of findings and which cannot be used to infer causation. Finally, the vast majority of existing research has employed the construct of ‘countertransference’ to understand and interpret the processes which result in clinicians feeling affected by their work. This implies that any impact of work in eating disorder environments is driven by patient transference and conscious or unconscious need. Limited attention has been given to exactly how clinicians may experience and make sense of any change, along with how other factors may impact clinician experience (such as culture, environmental factors, and so on). The only study found which attempted to move away from the framework of countertransference and take a broader view of the impact of the work on clinicians concluded that participants were either consciously or unconsciously being untruthful in their responses (Swancott, 2012). Therefore, this study sought address the paucity and poor quality of existing literature by exploring the following questions:

- 1. Do clinicians working in inpatient eating disorder setting experience changes to their body image, eating habits and perceptions of food (either positive or negative)?**
- 2. How do clinicians experience and make sense of these changes?**
- 3. What do clinicians feel contributes to these changes, and what helps clinicians to cope?**

8. Method

8.1 Design

The study used a qualitative approach, using a grounded theory approach. Grounded theory was selected, as currently there is very little information focusing on how working in eating disorder settings may impact clinicians, with the majority of established research being descriptive in nature. Therefore, grounded theory may be beneficial to begin constructing a theory of how working in an eating disorder setting may influence staff body image and eating habits. The Strauss and Corbin (1998) version of grounded theory was used, due to the focus on validation, abduction and the greater emphasis on broader environmental factors. Additionally, it has been suggested that the account of grounded theory proposed by Strauss and Corbin (1998) is more consistent with postpositivism and critical realism (Charmaz, 2000), which fits with the epistemology of the researcher.

8.2 Participants

In total, thirteen people participated in the study, of which eleven were female. Participants were all members of staff working at one of two private inpatient adolescent Eating Disorder hospitals. Five participants were between the ages of 20-24 years old, seven were between 25-29 years old and one was between 30-34 years old. In terms of ethnicity, five reported that they were English/Northern Irish/Scottish/Welsh, one reported that they were Irish, and two reported that they were white – other. Three reported that they were African, and two reported that they were black – other. Nine of the participants were therapeutic care workers/healthcare assistants for at least a portion of their week, with three of these also being assistant psychologists part of the time. One was a qualified nurse,

while the remaining participants had other job roles within the team. For confidentiality purposes, these jobs will not be reported, as it is likely that participants could be identified. Most participants were reasonably new to eating disorder work, with seven working in this environment between 0-1 years. Five has been working in eating disorders from 1-2 years, and one between 3-5 years. Finally, five participants said that they had previous histories of disordered eating. Of these, two had prior diagnoses of anorexia nervosa, one had a prior diagnosis of Eating Disorder Not Otherwise Specified (EDNOS), and two disclosed prior histories of restriction without receiving a formal diagnosis of eating disorder.

. Initially, a minimum of six months of experience of eating disorder-related work was required; however this was subsequently removed following consultation with both staff and supervisors.

Participation was based on opportunistic sampling. The lead researcher attended three staff meetings and the information sheet was circulated, with staff who were interested in taking part encouraged to make contact with the lead researcher to express any interest and find out more. As an incentive for taking part, all staff who participated were entered into a draw to win one of three £10 vouchers of their choice.

8.3 Procedure

An email with the study information sheet (see Appendix B) was circulated to all staff by the lead clinical psychologist for the service and external supervisor for this project.

Additionally, the lead researcher attended the research team meeting, a psychology team meeting and a ward meeting to discuss the research being conducted, with the request that this be cascaded to team members. Hard copies of the information sheet were also

provided, which contained the email address of the lead researcher. No deception was used during this study, so all participants were informed of the nature of the study and what was being explored.

If participants made contact to express interest, initially the standard reply was to re-send the information sheet, request that the participants read through to check that they were informed of the study, and to invite the participants to ask any questions. Once participants confirmed that they had read the information sheet thoroughly and all questions were answered, participants were asked for times and dates that suited them to meet individually with the lead researcher to complete the interview.

All face-to-face interviews took place in a quiet therapy room within the private hospital.

Three of the participants were unable to take part in face-to-face interviews due to issues with either being unable to get time away from the wards to take part, or due to a strong desire for peers to remain unaware that they had been interviewed for the project.

However, as these three participants were particularly keen to participate, after discussion with the external supervisor it was decided to conduct the interviews by telephone. These participants received a copy of the consent form and demographic sheet prior to interview (Appendix C and D respectively).

At the beginning of the interview, consent, confidentiality, right to withdraw and the anonymising of data were all explained. Permission was sought to audio record the interviews and participants were given another opportunity to ask any questions or raise any concerns that they may have. Face-to-face participants were then asked to complete the consent form and demographic sheet, and those being interviewed via telephone were read the consent form and asked for verbal consent, with the written consent to be provided immediately after the telephone interview. Providing that participants were happy

to continue, the interview was then conducted, using the interview schedule provided in Appendix E. General areas of discussion were past experiences (including questions on body image and eating habits), adult experiences (including body image and eating habits), experiences since working in inpatient eating disorders (including any changes to body image/eating habits and experiences of patients), experience of building therapeutic relationships and any notable protective or risk factors. All interviews were recorded using a Dictaphone. Interviews varied in length, but were between approximately 40 minutes to an hour in length, depending on the amount of information that participants had to share. Following the interview, participants were once again asked whether they had any questions. They were then given a full debrief about the project, including the ideas being explored and the expected completion and submission dates. Participants were then asked about how they experienced the interview, whether it raised anything difficult for them and whether they had any concerns about the impact that the interview had on them. One participant raised that it made them realise how angry they were at the lack of support received from their employer, which was discussed, with the participant being directed to use clinical supervision to talk about this. No other participants raised any concerns. Finally, participants were provided with a contact sheet of useful phone numbers, should they be worried about the mood, body image or eating habits of themselves or others (Appendix F). Interviews were immediately transferred from the Dictaphone to an encrypted, password protected USB stick and were re-named with a random participant number from 1-20. Participants were given this number and advised to quote this should they wish to withdraw from the project. For those being interviewed by telephone, both the list of telephone numbers and the participant number were sent via email immediately after the conversation ended.

8.4 Ethical considerations

Ethical approval was obtained from both the Salomons Centre for Applied Psychology and the research/ethics board of the hospital recruited from. However, consideration was given to the fact that participants being interviewed may have had their own previous experiences with eating difficulties. Additionally, some participants may have experienced significant changes to their eating habits and body image since beginning their work in eating disorder settings that they experienced as being negative. Therefore, time was set aside after the interview was completed to 'check in' with participants, and to discuss anything that may have come up that might have been experienced as personally difficult. Although this was not to be considered as therapy, it was decided that a space to think about any difficulties experienced and where to go with them would be beneficial for participants. Additionally, all participants were provided with a sheet containing contact details for various organisations, which may be useful if they were worried about the mood, eating habits or body image of either themselves or their colleagues (Appendix F).

8.5 Data analysis

Interviews were transcribed, and then analysed using the Strauss and Corbin (1998) version of grounded theory. This version was chosen, as it is thought to be more consistent with postpositivism and critical realism (Charmz, 2000), which was considered to be congruent with the epistemology of the researcher. Transcripts were initially coded using open coding, followed by selective coding. Codes were then considered in relation to each other, and

were arranged into categories and subcategories. Finally, a diagrammatical model was created which sought to explain how these concepts related to each other. Memos were kept throughout the coding process to track theory development (see Appendix G for examples).

8.6 Potential bias and use of bracketing

Strauss and Corbin (1998) highlight that interviews and data analysis do not occur in a vacuum; rather, the interview process and the subsequent data gathered are a complex interchange of participant experience and researcher interpretation, resulting in data that is co-created between the researcher and participant. Therefore, interviews and subsequent data analysis cannot be completely free of the preconceptions and experience that the researcher brings. However, to minimise bias, a number of bracketing techniques were used.

Although a traditional bracketing interview (Rolls & Relf, 2006) was not used, other methods have been suggested to bracket preconceived ideas which may interfere with the researcher's ability to engage with emerging data (Tufford & Newman, 2012). Therefore, the researcher used both memoing (Cutcliffe, 2003; Glaser, 1998) and reflexive journaling (Ahern, 1999) in an attempt to identify emerging beliefs and preconceptions which may have had a deleterious effect on the research if otherwise left unacknowledged. Examples of memoing and reflexive journaling can be found in Appendices G and H respectively.

8.7 Rigor and multiple coding

In an attempt to improve rigor, multiple coding was employed. Two independent peers drawn from the cohort of trainee clinical psychologists coded a transcript each. The assigned

codes were then discussed with the lead researcher. Generally, the codes assigned by the two independent peers were similar in nature to the codes assigned by the researcher, although with varying names. However, after discussing the concepts behind the codes, it became apparent that similar concepts were being highlighted.

9. RESULTS

During the interview and analysis process, three core categories were defined. These were: ‘past perceptions of self, body and eating’, ‘perceived changes’ and ‘participant reasoning of changes’, with ‘perceived changes’ being identified as the central category. Each of these categories consisted of a number of subcategories (see Table 2). Appendix I shows an example of a coded transcript, while Appendix J depicts the full coding table.

Figure 1 illustrates the hypothesised manner in which these concepts interplay to both create and maintain perceived changes to participant body image and eating. Historical perceptions of the self are proposed to develop within a social and familial context, forming a personalised background of beliefs around food, body image and exercise. Once working within an inpatient eating disorder setting, participants spoke about a complex interplay of the environment, the job almost seeming to promote chaotic eating, access to support and the impact of the patients themselves. These factors contributed to perceived changes to their food intake and body image, with aspects of their work spilling into their personal lives. These changes were then mediated by individual differences in management and the “personalised meaning” that participants assigned to changes. Once these changes had been noticed, ascribed a meaning and managed, participants gave further consideration to the work environment, access to support, availability of food due to their job and the impact of their patients, which had a further impact on the perceived changes. It is important to

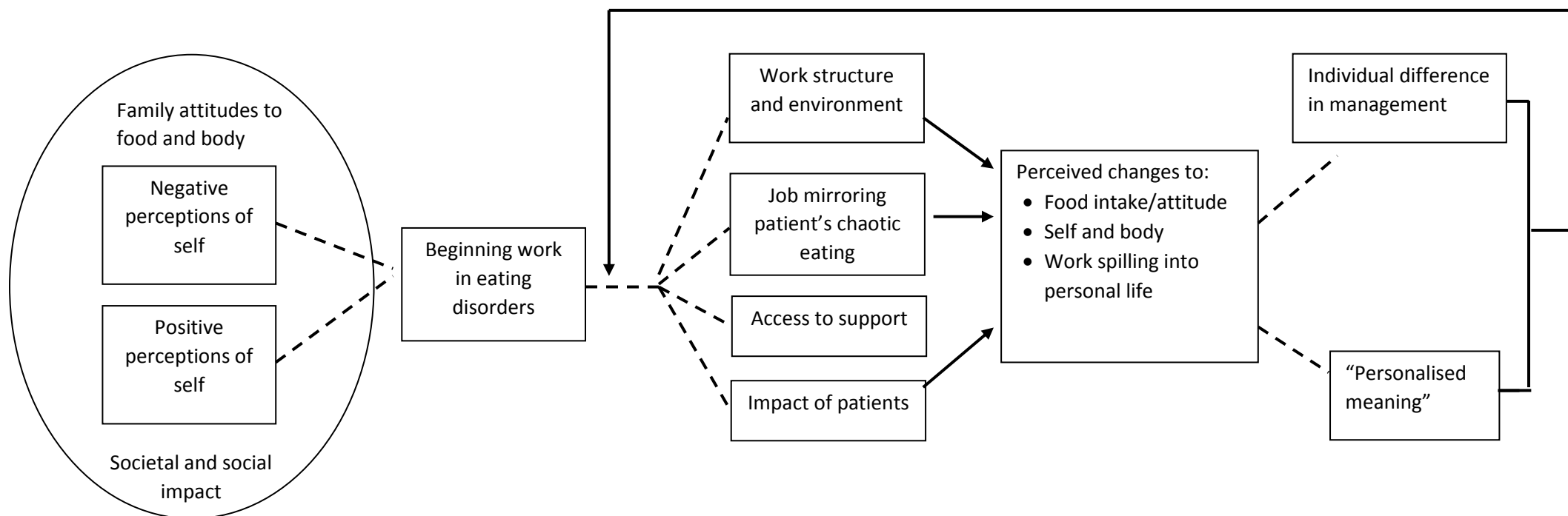
highlight that the changes noticed could be experienced as being positive, negative, or

Core category	Sub-category
Past perceptions of self, body and eating	Societal and social impact
	Family attitudes towards food and body image
	Positive perception of self
	Negative perception of self
Perceived changes	Changes to food intake and attitudes
	Changes to perception of self and body
	Work spilling into personal life
Reasoning of changes	Work structure and environment
	Job mirroring patient's chaotic eating
	Impact of patients
	Access to support
	Individual difference in management
	"Personalised meaning"

neutral.

Table 2: *Core categories and subcategories*

Figure 2: Diagram of hypothesised theory of perceived changes



Each of the three core categories and their subcategories will now be described, with quotes drawn from interview transcriptions to support and illustrate categorisation.

9.1 Core category 1: Past perceptions of self, body image and eating

9.1.1 Family attitudes towards food and body

Participants described a number of experiences from their childhood and adolescence around the ways in which family attitudes towards food shaped their perceptions of eating and their body. These experiences formed the bases of the attitudes and experiences with which participants entered the eating disorder environment, potentially shaping the reactions that were subsequently elicited. These attitudes varied widely, including the idea that food is necessary nourishment and should be consumed as and when needed as well as stories of unhealthy familial relationships with food. The cultural importance of food was also raised a number of times by participants, particularly those whose parents were from different cultures.

P03: *"...my family background, my culture...they encourage you to eat!"*

P 13: *"...and even just being away from home, it made me realise that my mother had quite an unhealthy obsession with weight"*

9.1.2 Societal and social impact

Naturally emerging from the data were descriptions of the impact that wider societal expectations and socially reinforced ideas had on participants. Many participants spoke about the socially ideal body types that they were encouraged to strive for, along with the impact that their peer group's perceptions had on their own desired body type. Some participants described feeling less pressurised to conform to a socially prescribed ideal,

largely due to the fact that their body already naturally met the desired type imposed by society. Many participants spoke about changes to their weight – either due to attempts at dieting or through a variety of other factors, such as changes to external circumstances – with the subsequent reaction from family and peers either positively or negatively reinforcing their new bodies. Gender was also raised as an idea here – although interestingly, it was only raised by the men who were interviewed.

P07: *“once I’d lost it (weight), and I went back to my second year at uni, and everyone was saying oh wow you look amazing kind of thing so there was pressure to keep it off”*

P13: *“the desired body type was almost androgynously thin, and seemed to be desired by the girls at school and the boys in the local school”*

9.1.3 Negative perception of self

Many participants spoke about a historically negative perception of themselves. This generally comprised participants feeling ‘overweight’, particularly in comparison to their peers. However, the extent to which these negative perceptions of the self impacted daily functioning of participants ranged from low self-esteem and a general feeling of difference, to diagnosed eating disorder histories.

P03: *“...I always felt kind of chunky, like compared to other friends at school...and when I was growing up I did try different diets...”*

P06: *“...by the time I was like 14 I actually did develop anorexia and had really bad body image”*

9.1.4 Positive perception of self

Although many participants highlighted negative ideas of themselves, historically positive ideas around body image also emerged from the data. Along with a general lack of consideration towards the body, some participants spoke about feeling as though their body met the socially desirable standards of shape and size – generally, that of being slim. Additionally, those who had experienced eating disorders previously generally spoke about a process of moving towards a more positive and accepting view of the self in which past difficulties were (at least partially) reconciled. Therefore the same participant would often speak about both positive and negative perceptions of themselves within the same interview.

P10: *"I've always eaten what I wanted and never really excessively put on weight, like the idea that I need to lose it isn't a big part of anything for me, so I am quite happy with how I am"*

P13: *"I realised that actually I had a normal body shape and really, it was probably on the smaller end of the spectrum...and for me it was the first time since childhood that I felt completely at ease with my body"*

9.2 Core category 2: Perceived changes

9.2.1 Changes to food intake and attitudes

Participants described a wide variety of changes to their food intake and attitudes towards food occurring since working in an inpatient eating disorder setting. Most commonly, participants felt as though they were increasingly aware of the calorie content of food. However, the subsequent impact that this had on participants' actual intake of food varied widely. Many participants noted that they felt an increased desire for health, and often modified their intake accordingly. However, comfort eating, weight gain and a shift to eating

more unhealthy food were also widely noted with varying explanations as to why participants felt this was occurring. Missing meals or restricting calories also emerged, however this was to a lesser extent.

P04: *"I shouldn't really wanna eat that but then I've found myself just eating it"*

P10: *"I'm more conscious of what's in food, in terms of calories or fat and things because before I never really thought about it at all"*

9.2.2 Changes to perception of self and body

In tandem with perceived changes to food intake and attitudes, an emerging category of changes to perception of the self and body image became apparent. Although a generally increased awareness of the body was dominant in the data, many participants spoke of additional changes that had become noticeable during the course of their work. Changes to the body types which were considered desirable appeared to be a particularly prominent concept – however, there was a range of variety, with some participants seeing thinness as less desirable, others wishing for a more 'curvaceous' figure, and old body image concerns resurfacing in which thinness was seen as the ideal to be aspired to.

P05: *"for me I don't think I'd want to be skinny anymore, I don't think I'd want to be skinny, but at the same time my ideal is being a bit curvier now"*

P13: *"I just find my focus shifting back onto my body in a way that I hadn't been troubled by since I was 18...I just find myself constantly feeling like one of the bigger people in that small, intense community of girls..."*

9.2.3 Work spilling into personal life

Participants not only spoke of changes to their body image and ideas of food, but also to their general individual behaviour. The described changes to behaviour all shared the common theme of aspects of work being adopted in participants' personal lives, from generally being more aware of the behaviour and body size of others to incorporating behaviours from work into their own repertoire.

P04: *"I remember outside of work around meal times, I was getting anxious, and it's so ridiculous, but I did"*

P05: *"...you know when they are eating you're meant to make sure most of the food is off the plate like scraping and stuff, like when I eat now, I don't leave excess food on the place cos you sit there and you think like oh actually you need to keep going"*

9.3 Core category 3: Reasoning for changes

Emerging from the data were distinct subcategories comprising the sense that participants made of the changes presented above. Interestingly, these seemed to fall into two broader categories – the impact of the broader work environment, which participants appeared to feel 'caused' the changes, and the differences in the ways that participants individually managed these processes.

9.3.1 Work structure and environment

A clear concept of the work structure and the nature of the job itself became apparent. Participants spoke about aspects of the job which, when done regularly enough, became part of their repertoire of behaviours – such as remaining hyper vigilant to others, or modelling specific behaviours. Participants also spoke about the information that was accrued during the course of their work which subsequently could not be ignored, such as

the accumulation of knowledge about the calorie content of food due to the weighing of food within the job role.

P10: *"...you have to get the kid's calories right because food is essentially their medicine, so there's no way of not knowing how many calories are in, like to a certain gram of yoghurt you know, so it just- it becomes a routine, you know you go in the morning, you do their breakfast, this child has this many calories which looks like this, the cooking you do is based on calories per portion so, you have to know it really really well"*

P11: *"I have set meal times where I have to eat in front of patients, and they're watching you to see how you eat and, part of our job is modelling good behaviours, you have to be aware of what you're doing in front of patients"*

9.3.2 Job mirroring patient's chaotic eating

Interestingly, numerous participants also spoke about the fact that the job almost appears to promote a chaotic or disordered pattern of eating. In particular, the nursing team (comprising the healthcare assistants and nurses) began their shift at between seven thirty and eight o'clock in the morning, and usually would not have their lunch break until around three or four o'clock in the afternoon. Many participants spoke about either eating more due to becoming extremely hungry, or missing later meals due to their late lunch, resulting in participants only eating once or twice in the course of the day.

P04: *"it's a 13 hour shift so you get your hour break but you won't get it 'till three or, about that time, like three or four, and I don't eat in the mornings, so I don't eat until....I don't usually eat until about four"*

P09: *"...most of the time when they get a lunch break it's at 3, 4, or 5, I've been working since 7am, so I've gone quite a few hours without stopping...but we, staff members who don't*

have eating disorders are forced into abnormal behaviours where they're going hours on end starving, and you can't eat anything"

9.3.3 Impact of patients

A complex interplay between the participants themselves and the patients that they were there to help support emerged from the data, in which patient-driven factors were thought to contribute to the overall sense of change that participants described. Participants often felt as though their bodies were being 'scanned' or 'checked' by their patients, with patients commonly engaging in body checking behaviours both during and after analysing participant bodies. Additionally, several patients had commented on staff bodies – either positively or negatively. This process of patients attending to participant bodies often brought the bodies of staff sharply into focus, with participants describing the general level of attention given to body weight, shape and size as contributing to their own awareness and consideration of their physicality. Additionally, the process of spending a significant amount of time amongst people of the level of thinness common in inpatient eating disorder setting was also described as having an impact on participants, with many describing a feeling of 'bigness' compared to small, underweight patients. Conversely, participants also spoke about their shock and disgust at extreme levels of thinness, which enabled participants to witness the impact of anorexia and extreme thinness. Furthermore, the amount of time spent with patients was considered to be a factor contributing to the level of change noticed by participants, with several of those who spent a significant proportion of their day (for example, healthcare assistants and nurses) describing how the process of simply being around patients for so long resulted in them feeling more susceptible to being negatively affected by their work.

P07: *"I wondered if it's helped, the fact that I'm not so on the floor, so I'm more removed, so I'm not on the front lines"*

P08: *"...there's nothing nice, there's nothing healthy, there's nothing good about it"*

P13: *"well it constantly feels as though patients are scanning your body, just sort of observing it or judging it, maybe in relation to their own, and I've had a couple of patients tell me that they are much bigger than me when, I mean clearly they're much smaller...and I find that, it's like a jarring reminder of my own body shape and size"*

9.3.4 Access to support

Availability of support emerged as a particularly common concept across participant interviews. Specifically, the extent to which participants felt supported by their peers, and the availability of spaces to discuss the emotional intensity of their jobs – for example, regular supervision – was described as having a large effect on the extent to which participants felt affected by changes to their eating and body image. Having space to consider the impact of the work on the self was repeatedly highlighted as helpful by those who received it, and needed by those who did not.

P06: *"so the top thing for me that's helped is supervision"*

P09: *"having a reflective practice space would be so helpful, even if I can't talk about my personal struggles, I could talk about my struggles on the ward in general"*

9.3.5 Individual difference in management

Participants repeatedly spoke about the role of pre-existing individual difference in the ways in which they made sense of and responded to potential changes while working in eating disorder settings. Historical ideas of body image and eating, cultural ideals, and external

activities were all described as being central to managing the intensity of working within eating disorders. Additionally, body shape and size was described as being potentially protective, with several of the participants with smaller body sizes wondering whether their experiences may differ if they were 'heavier'.

P05: *"in terms of my race growing up, my sister is quite curvaceous, nice figure and stuff...that's what a lot of black girls aspire to"*

P08: *"..having the knowledge like through doing psychology ... maybe that's helped as well, and just having a normal home environment where your eating was very relaxed"*

P10: *"...if I was more self conscious about it or if I was noticeably a lot more...heavier, I guess that would make it harder"*

9.3.6 "Personalised meaning"

This in-vivo subcategory was concerned with the meaning that participants constructed from their work, and encompassed the ideas of participants being 'on a journey'. During this process, participants described perceiving and responding to their own developing sense of self.

P05: *"...there are more important things to life than how you look, although sometimes people may not realise that...that's what this place has made me feel like"*

P06: *"...in the context of everyone's individual processes, I've been able to take away a little bit of meaning of my own from that"*

10. DISCUSSION

The aim of this study was to consider the ways in which staff body image and ideas of food may be affected by working in adolescent inpatient eating disorder environments, and to begin explaining why this may occur. The analysis described above attempted to describe and present the experiences of a range of staff working within adolescent inpatient eating disorder environments, to begin addressing this question. The model presented hypotheses that a complex interplay between pre-existing ideas of food and body image and the work environment itself contribute to perceived changes, which are then given meaning and managed by the individual. The way in which these changes are interpreted and managed then results in further interaction with the work environment and potentially further perceptions of change, resulting in a cyclical relationship.

10.1 Fit with previous research

The results of this study appeared reasonably consistent with the limited research previously undertaken within the area, indicating that the experiences discussed may not be confined to the two private hospitals used for recruitment. Experiences described by participants, such as feelings of 'bigness' compared to small patients (Walker & Lloyd, 2011), patients analysing or scanning staff bodies (Daly, 2012; Frankenburg, 1984; Warren et al., 2009), increased awareness of body size and shape (Daly, 2012; Derenne, 2006; Lowell & Meader, 2005), and changes to ideas of food and food intake (Shisslak, Gray & Crago, 1989; Warren et al., 2009) have all been noted in previous research. Additionally, the propensity to interpret changes to body image and perception of food as being either healthy (Shisslak et al., 1989; Warren et al., 2009) or unhealthy (Warren et al., 2009), regardless of previous eating pathology (Shisslak et al., 1989) indicates that there is no clearly defined process of

change dependent on previous eating history and body image. Although this piece of research attempted to identify and explain the changes that participants may experience independent of theoretical orientation, the processes described may be situated within established psychological theory. For example, the concept of countertransference within psychodynamic theory (Racker, 1968) describes the process in which therapists experience reactions in response to the transference of the patient. When left unanalysed, these countertransference reactions may be identified as being derived internally from within the therapist rather than being induced by the transference of the patient. Therefore, the changes experienced by staff working in eating disorders may be viewed as unnamed and unprocessed countertransference. However, this does not seem sufficient to explain the changes experienced by clinicians entirely, as a number of factors other than the patients themselves were described by participants (such as cultural ideals, the structure of the environment itself, historical ideas about food/diets, previous eating disorder pathology, access to support, and so on.). An alternative framework which may encompass some of these other factors is that of Narrative Therapy. Narrative theory postulates that people give meaning to the events experiences throughout their lives, constructing a dominant story, or 'narrative' (Morgan, 2000). This seemingly fits with the subcategory of "personalised meaning", in which participants derive individualised meaning from their experiences within eating disorders. Additionally, the way in which participants construct their identities prior to working within eating disorder settings – for example, as being 'slim', 'attractive' or 'not needing to diet' – may impact the aspects of experience which they choose to attend to and add to their repertoire of experiences which contribute to the dominant narrative of themselves. Meanwhile, more feminist theories may describe the process by which women are designated as being 'powerless' within society. Therefore, women are socialised to

believe that their value rests on their ability to attract the more powerful, dominant men who are able to provide financial security. This process of reducing a woman to her ability to attract a mate results in a woman's worth becoming tied up with her physical appearance, resulting in competition between women and feelings of worthlessness when women are unable to meet the ideals imposed on them by society (Bloom et al., 1994; Bloom, 2002; Orbach, 2006). As such, when women enter an environment such as that of an inpatient eating disorder unit in which they are surrounded by focus on weight, body image and eating habits, they may begin to question their own value and ability to meet society's expectations. Additionally, their prior socialisation regarding the desirability of thinness and the location of their value in their physical attractiveness may mean that they are pulled into a process of competition with other women – namely, their patients. Regardless of the theoretical underpinning used in an attempt to understand the processes occurring, what remains clear is that there does indeed appear to be a process in which staff are impacted by their work, whether that be interpreted as being positive or negative.

10.2 Limitations

Although attempts were made to increase the credibility, transferability and dependability of the study, there were still a number of limitations.

Firstly, organisational difficulties, limited resources and time constraints resulted in a reasonably small number of participants. Therefore, many of the concepts did not reach saturation, but rather theoretical sufficiency was used instead. Therefore, it is entirely possible that a larger sample size may have resulted in further concepts emerging, which may have subsequently affected the model hypothesised to explain the process of change to body image and eating habits described by staff. Further research using a larger sample

would be needed to assess whether the same concepts continue to emerge from the data, and whether there may be further categories or subcategories which were not uncovered during this project.

Additionally, although the project was open to all members of the multidisciplinary team, the vast majority of those taking part were either healthcare assistants or assistant psychologists. It is entirely possible that the lack of formal clinical qualifications, lower degree of supervision or the higher level of contact time with the patients inherent within these job roles in particular may have resulted in these staff members noticing the highest degree of change, resulting in them feeling a stronger desire to participate; however it is also entirely possible that there are other factors which may have affected the willingness of other staff groups to participate in this study. Therefore, the hypothesised model constructed may not be transferrable to others working within eating disorders outside of the job roles stated. Additionally, recruitment was based across two private inpatient adolescent inpatient hospitals. Results therefore may not be transferrable to those working in NHS settings, outpatient/community settings, or those working with adults. Further research would therefore be required to assess the transferability and replicability of the categories and hypothesised model.

Finally, although attempts were made to increase rigor and limit potential researcher bias, the epistemological standpoint of the researcher remains that the experience of others cannot be independently and impartially measured. The co-construction of interview data takes place through a combination of questions selected by the researcher, participants' expression of experience (coupled with the experiences that they choose not to share) and subsequent interpretation of these shared experiences by the researcher. Therefore, this

process cannot be completely independent of the researcher's influence despite attempts to identify and minimise this where possible.

10.3 Clinical implications

The data from this study suggests that many of the changes experienced by staff are experienced as healthy or positive. For staff themselves, this may have a positive impact on their wider quality of life and view of self; however this may also have a positive impact on their ability to interact with patients – particularly with regards to modelling healthy attitudes towards food and body image (although further research may be needed to explore this). However, the implications regarding those who experience negative changes are far more significant.

Although previous research has highlighted the role of supervision in preventing exhaustion and burnout in those working within mental health settings across multiple different professions (Edwards et al., 2006; Spence, Wilson, Kavanagh, Strong & Worrall, 2001), participants within this study frequently described a lack of supervision, which was often discussed in relation to the more difficult processes described. If availability of support does have an impact on the changes staff members experience in relation to their body image and eating habits, then the importance of providing regular, frequent and adequate supervision for staff cannot be understated.

Additionally, the structure of the environment itself emerged as a subcategory within the category of perceived change, indicating that there may be something in the structure of inpatient adolescent eating disorder environments which causes or contributes to the changes described. While some of these organisational processes may be more obviously difficult (for example, staff members being required to work for around eight or nine hours

before getting a break to eat or drink water), it appears as though other processes may also be affecting the staff – for example, the requirement for staff to calculate food calories for patients. Organisations may therefore wish to reconsider the duties which are allocated to staff, or implement further support networks in an attempt to allow staff to have a space to discuss how the organisational structure in itself may affect them.

10.4 Further research

As previously mentioned, further research is required to assess whether the model proposed is transferrable to other staff groups and settings, and whether it is replicable. However, as research into the ways in which staff may be affected by their work is still a reasonably new area, this project also raises a number of other questions.

One such area for further exploration is whether implementation of supervision along with other spaces for staff to discuss their experiences during the working day may affect the level of change experienced by staff, or the meaning made of these experiences.

Additionally, spaces to explore previous body image concerns – particularly those which may be unresolved – and how these may be affected by the weight and food focused environment of an inpatient eating disorder environment would also be an interesting consideration for further research. Furthermore, it may be interesting to use quantitative analysis in an attempt to identify whether there are particular factors which may explain the difference in whether positive or negative changes are experienced, and the extent to which these affect the individual.

Finally, one of the considerations which struck the researcher was the fact that many of those interviewed identified themselves as having previous eating disorder histories. While some of these participants appeared to find the nature of the environment ‘triggering’,

many others spoke of moving towards a place of bodily acceptance and increased health during the course of their work. Indeed, many of the participants spoke about their shock at not being more affected by their work. As such, future research may wish to explore the way that those with previous histories of eating disorders manage these environments, and the way in which they construct their new identities as 'staff' rather than 'patient'.

11. CONCLUSION

While there is some evidence to suggest that those working in eating disorders do experience changes to their body image and eating habits, whether these are experienced as positive or negative and the extent to which they affect participants' lives is varied. While some participants felt as though they moved towards more disordered eating or problematic body image, others reported feeling as though they were now engaging in more healthy eating, with a more positive view of the self. A model of changes to body image and eating habits was presented, in which a complex interplay of pre-existing attitudes towards the body and eating, the inpatient eating disorder environment itself, access to support and interactions with patients contributed to the development and maintenance of changes to body image and eating habits. The meaning that participants ascribed to these changes and their individual attempts at management then had a further impact on the extent to which participants felt changes were helpful or harmful. Generally, the results obtained and the hypothesised model of change fit with previously conducted research into the area, and can be situated within wider psychological theoretical underpinnings. However, limitations within the methodology along with a small sample size mean that further research into the area is needed.

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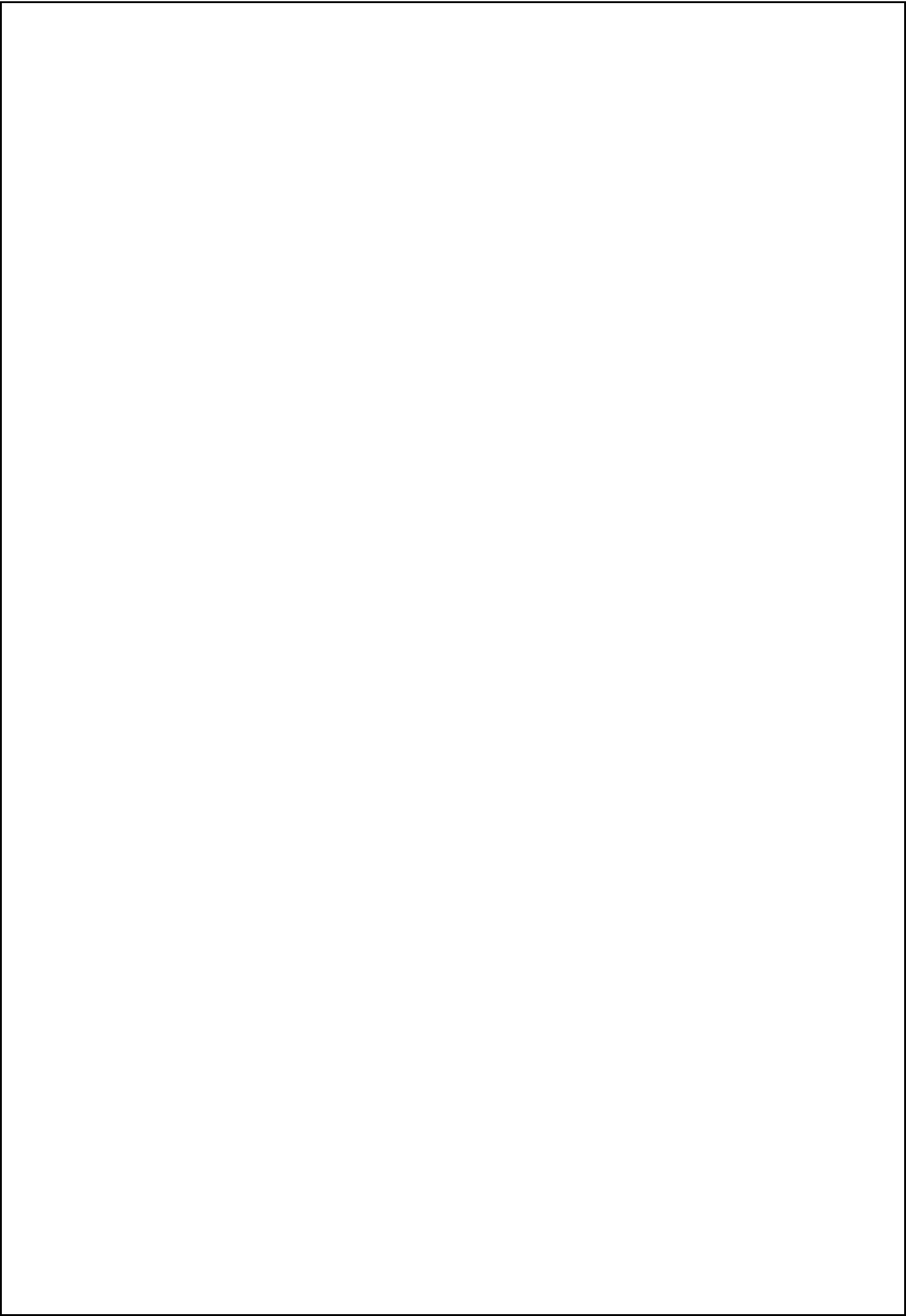
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Section C: Appendix of Supporting Material



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*'In a dark place we find ourselves, and a little more knowledge lights our way'-
Yoda*

Summary of major research project

Section A - This section focuses on existing research into countertransference experienced by clinicians working in eating disorder settings. A number of different forms of countertransference have previously been highlighted, including emotional countertransference and physical countertransference. Additionally, working with clients with eating disorders has been linked to changes in clinician's perception of their own body and has been thought to have an impact on team processes. Finally, there is some suggestion that different eating disorder diagnoses may affect the countertransference experienced. However, existing research tends to rely on single case studies and limited samples of clinicians. Furthermore, existing literature into the changes experienced by clinicians utilises the largely psychodynamic/psychoanalytic framework of countertransference, with limited research papers outside of this theoretical orientation.

Section B - This section aimed to develop a model which explains the changes to body image and eating habits experienced by clinicians working in eating disorder settings from a pan-theoretical standpoint. Thirteen members of staff working within two private, adolescent inpatient eating disorder hospitals were interviewed about their previous eating habits and body image, as well as any changes experienced since beginning their work in eating disorder settings. Participants had a wide variety of job roles; however, the majority of participants were healthcare assistants/therapeutic care workers or assistant psychologists. Interviews were analysed using a Grounded Theory approach, and three core categories were developed. These were past perceptions of self, body image and eating, perceived changes and reasoning for changes. A theoretical model was developed to explain the relationship between these categories, and how concepts such as pre-existing body image,

ideas of food, the work environment, access to support, the impact of patients themselves and promotion of chaotic eating through the work itself interplay to create change. How these changes are perceived and managed is then influenced by individual differences and the “personalised meaning” ascribed.

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Section A: Eating Disorders, countertransference and the impact on
clinicians: a review

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1. ABSTRACT

The countertransference experienced by staff working in mental health settings is an area which has received some attention in psychodynamic and psychoanalytic literature. Eating disorder work represents an area of particular complexity due to the high levels of mortality, suicide, ambivalence to treatment and co-morbidity. However, the countertransference experienced by staff working specifically in eating disorder settings remains a relatively new area of research.

Electronic databases were searched for studies of countertransference that may be experienced by staff working in eating disorder settings. Sixteen studies were identified, which differed in their methodology, clinicians included, and findings. The quality of the studies analysed is considered, and a synthesis of findings is given.

Although there is some evidence to suggest that staff working in eating disorder settings may experience a high level of countertransference, there is a general paucity of research, with most studies being of relatively poor quality and drawing on limited pools of clinicians. Implications for clinical practice and for further research are discussed.

2. INTRODUCTION

2.1 Overview

The term 'Eating Disorders' is an umbrella term applied to a range of psychological disorders, all of which have abnormal eating patterns as their core diagnostic criteria. These abnormal eating patterns result in changes to physical and/or psychological functioning. While a range of disorders fall under this umbrella term, the most common are Anorexia Nervosa, Bulimia Nervosa, Eating Disorder Not Otherwise Specified (EDNOS)/Other Specified Feeding or Eating Disorder (OSFED) and the more recent addition of Binge Eating Disorder (in Diagnostic and Statistics Manual, Fifth Edition, American Psychiatric Association, 2013). Although Binge Eating Disorder is grouped in the same diagnostic category as the aforementioned, it is thought that the underlying mechanism may be more akin to a food addiction as opposed to the idealisation and pursuit of thinness typically observed in Anorexia, Bulimia and EDNOS (Schulte, Grilo & Gearhardt, 2016).

2.2 Prevalence, recovery and mortality rates

Current estimates suggest that around 725,000 people in the UK have an Eating Disorder (PwC & Beat, 2015); however, research suggests that 6.4% of all adults in the UK exhibit some eating disorder symptoms (Health & Social Care Information Centre, 2007). Although the majority of those with eating disorder diagnoses are females, estimates suggest that between eleven percent (National Institute of Clinical Excellence guideline CG9, 2004) and twenty five percent (Beat, 2010) of eating disorders occur in males. Additionally, the number of individuals diagnosed with eating disorders appears to be rising faster in males than in females (Micali, Hagberg, Petersen, & Treasure, 2013). Although eating disorder onset can occur at any age, the average age of onset is between sixteen and seventeen

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years for Anorexia, and between eighteen and nineteen years for Bulimia (National Institute of Clinical Excellence guideline CG9, 2004), with those under the age of twenty accounting for approximately 49% of all eating disorder inpatient admissions (Royal College of Psychiatrists, 2014).

Treatment of Eating Disorders continues to be problematic. Where treatment is prompt, approximately 46% of those with Anorexia and 45% of those with Bulimia will make a full recovery, while 33% of those with Anorexia and 27% of those with Bulimia will show significant improvements. However, 20% of those with Anorexia and 23% with Bulimia will continue to experience long-term, chronic difficulties with eating (Beat, 2010). The chronic nature of eating disorders often results in medical complications, and the psychological difficulties associated with eating disorders can often result in suicide (Harris & Barraclough, 1998). Because of this, Anorexia Nervosa continues to have the highest mortality rate of all mental health conditions (Steinhausen, 2002), with estimates suggesting that Anorexia results in 5.1 deaths per 1000 per year (Arcelus, Mitchell, Wales & Nielsen, 2011).

2.3 Treatment

Treatment of eating disorders continues to remain problematic – largely due to the continued idealisation and pursuit of thinness, lack of insight into the severity of the illness, resistance and distorted view of the self as being overweight commonly seen in those with eating disorders (Vitousek, Watson & Wilson, 1998; Williamson, Muller, Reas & Thaw, 1999). Because of these difficulties, a wide range of psychological therapies are recommended for the treatment of eating disorders, including Psychodynamic Psychotherapy, Cognitive Behavioural Therapy, and Systemic Family Therapy, with limited evidence to suggest that any one therapeutic modality is superior (NICE guideline CG9,

2004). Nonetheless, psychodynamic psychotherapy continues to be one of the most commonly offered treatments for eating disorders across both adolescent and adult settings since the first psychological models of eating disorders were constructed with a psychodynamic underpinning (Brunch, 1962; Hartman 1958; Kay & Leigh, 1964). Traditionally, Psychodynamic Psychotherapies have been resistant to the rigorously evaluated research trials more commonly seen in Cognitive Behavioural Therapy, with practitioners preferring smaller, case-study approaches to illustrate efficacy (Fonagy, 2015); however this has been slowly changing, with an increasing number of studies attempting to evaluate the efficacy of psychodynamic psychotherapy in comparison to other treatment options (Abbass, Hancock, Henderson & Kisely, 2006; Fonagy, 2015; Leichsenring, Rabung & Leibing, 2004). As such, there is an emerging body of evidence to suggest that psychodynamic psychotherapy is an effective psychological treatment for eating disorders (Dare, Eisler, Russell, Treasure & Dodge, 2001; Treasure, Todd, Brolly, Tiller, Nehmed & Denman, 1995; Wild et al, 2009).

2.4 Transference and Countertransference

Transference and countertransference are two of the central tenets of psychodynamic psychotherapy. Transference can be defined as thoughts, feelings and behaviours which are originally experienced during childhood in relation to others (often caregivers), which are then displaced onto someone else later in life (Moore & Fine, 1990). Most commonly, this occurs within therapeutic relationships. Conversely, countertransference has been somewhat redefined over the years, with a split in the way that different schools of thought think of this. The more 'narrow' definition utilised by Freud (1910) and his fellow 'classicists' define countertransference as the unconscious responses of the therapist to the

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transference of the patient (Freud, 1910; Tosone, 1997). However, the 'broader' definition adopted by 'totalists' includes all reactions and feelings experienced by the therapist (both conscious and unconscious) in response to both the patient's transference and the patient's needs (Racker, 1968).

The importance of transferential and countertransferential reactions cannot be underestimated, as it is thought that these reactions give insight into the patient's early relational experiences, as well as their current internal world (Racker, 1968; Winnicott, 1949). However, it has also been long acknowledged that transference and countertransference reactions can significantly impact both the therapist and the therapeutic relationship. For example, Searles (1987) noted that patients with borderline presentations may make extreme demands on their therapist. Without proper analysis and containment of the transference and countertransference, the therapist may become lost or react inappropriately. Similarly, Racker (1957) argues that unexamined or unidentified countertransference reactions can often result in therapists 'retaliating' to their patient, while Epstein (1987) highlighted how therapists can be left with negative ideas of their own abilities, resulting in what Epstein (1987) termed the "bad-analyst feeling". Furthermore, it is common for therapists to experience hate (Maltsberger & Buie, 1974), hopelessness (Richards, 2000), ambivalence (Jackson, 1983), and even vicarious traumatising (Pearlman & Saakvitne, 1995), all of which can lead to the breakdown of the therapeutic relationship if not properly contained (Maltsberger & Buie, 1974). Furthermore, it has been suggested that it is the overall severity of psychopathology or the clusters of personality traits which result in the most dysfunctional countertransferences (Colson, Allen, Hamburg & Herzog, 1990), with more complex and severe presentations or those which are riskier resulting in the most intensely distressing countertransferences (Kleespies & Dettmer, 2000). A previous review

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conducted by Golan, Yaroslavski and Stein (2009) looked specifically at the psychodynamic perspectives on the development of eating disorders, and how these early experiences may contribute to transference and countertransference reactions which may be experienced by staff. The review concluded that the early interruptions, ruptures, and failure to internalise 'good objects' experienced in caregiving relationships (which are theorised to be behind the development of eating disorders in psychodynamic and psychoanalytic theory) result in the complex pattern of behaviour seen in those with eating disorders. The countertransference, therefore, is thought to be reflective of the internal reality of those with eating disorders (Golan et al., 2009).

2.5 Focus on countertransference

The decision was taken to focus the review on the idea of 'countertransference' rather than focusing more generally on the impact of eating disorder settings, as the impact of work on the self is a central tenet of psychodynamic and psychoanalytic thinking. This pre-existing emphasis on 'countertransference' often results in clinicians being extremely attuned to and aware of the impact that their work may have on themselves, resulting in a higher number of publications focusing on the impact of work environments on clinicians themselves.

Conversely, other theoretical frameworks (such as Cognitive Behavioural Therapy) have traditionally not encouraged clinicians to focus on their own experiences while in the room with clients, preferring to think about client experiences, mechanisms of change, or theoretical techniques. Therefore, there is no established terminology for the impact that work may have on the self within these theoretical frameworks. Preliminary literature searches into the area of changes experienced by clinicians were conducted to establish a

list of key words, which supported the idea that almost all pre-existing research into this area was framed using the concepts of countertransference.

2.6 Aims of the review

Those with eating disorders are at greater risk of mortality (Steinhausen, 2002) and suicidality (Arcelus et al., 2011; Harris & Barraclough, 1998). They are more likely to be resistant to treatment (Williamson et al., 1999; Vitousek et al., 1998) and to have high levels of co-morbidity, including anxiety disorders, depression, personality disorders, and post-traumatic stress disorders (Braun, Sunday & Halmi, 1994; Blinder, Cumella & Sanathara, 2006). Additionally, societal ideas around 'thinness' and 'fatness' are likely to reinforce the pursuit of weight loss typically seen in anorexia, giving eating disorders an aspect of social acceptability unseen in other diagnosable mental health disorders (Bloom et al., 1994; Bloom, 2002). Therefore, it seems plausible that clinicians working within eating disorder settings may be subject to some of the most personally difficult and distressing countertransference reactions. However, the previous review conducted by Golan et al. (2009) was composed mostly of theoretical papers and book chapters, resulting in more of a conceptual review, which focused on how the theoretical processes underpinning eating disorders may contribute to transference and countertransference. No assessment of quality was used, and there was no discussion of the research base currently available. Therefore, although this review is helpful as a conceptual review of the psychodynamic theory of eating disorders, it had limited application to the evidence base of how staff may be affected by countertransference. As such, the aim of this review is to assess and analyse the existing research literature pertaining to countertransference reactions experienced by

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clinicians working with patients experiencing eating disorders. For this purpose, the broader, totalist definition of countertransference employed by Racker (1968) will be used.

3. METHODOLOGY

3.1 Search

A preliminary search was performed, followed by a full search using the following terms:

((Eating Disorder) OR Anorexi* OR Bulimi*) AND ((Counter transference) OR countertransference)

As the term countertransference and counter transference is used interchangeably in literature, both terms were included. The Boolean operator 'AND' was used to combine unrelated word/subject areas, the Boolean operator 'OR' was used to ensure that articles using different eating disorders were included, and the truncate symbol (*) was used to ensure that all possible alternative terms (e.g. anorexia, anorexia nervosa, anorexic, etc.) were included. The search was performed using PsychInfo, Medline, PsychArticles, Social Policy and Practice, and the Canterbury Christ Church University Library Search. Google Scholar was also checked to ensure that no studies had been missed. The search was conducted between August and November 2016. The field search option was used in Ovid (used to search all of the above with the exclusion of the Salomons Library Search and Google Scholar) to limit the number of irrelevant results returned. Following the search, a manual search of all relevant articles identified was then conducted to identify other articles of potential relevance. Searches were limited to journal articles. No date range was used due to the relatively recent nature of most research papers in this area.

The titles of all search results were initially screened for relevance. Potentially relevant or ambiguous results were then considered based on their abstracts, with full-text versions of

articles being obtained for more in-depth consideration of relevance. A flow diagram depicting the searching and screening process can be found in Figure 1. Sixteen relevant studies were identified, which will form the basis of this review – see Table 1 for a full list of all studies reviewed with main discussion points.

3.2 Inclusion and exclusion criteria

To be included within this review, studies must have focused, at least in part, on the specific countertransference experienced by clinicians working with eating disorder patients, and the subsequent effect that these countertransferences had either on the clinician or on the therapeutic relationship. Single case studies and theoretical papers which included case material were included, as psychodynamic literature has previously favoured this method of dissemination.

Articles were excluded if any of the following criteria were met:

- The articles were not in English
- The articles did not mention countertransference processes at all
- The papers discussed countertransference processes in relation to other diagnostic categories with no mention of eating disorders.
- Papers were purely theoretical in nature, with no clinical material or case studies presented.
- The articles focused on countertransference in relation to Binge Eating Disorder. As previously highlighted, it is thought that the mechanism underlying Binge Eating Disorder may differ to those underlying Anorexia and Bulimia. Additionally the distorted perceptions of the self and the social reinforcement of the illness are not

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generally present in Binge Eating Disorder. Therefore the countertransference may differ.

- Books were excluded as they were beyond the scope of this review.

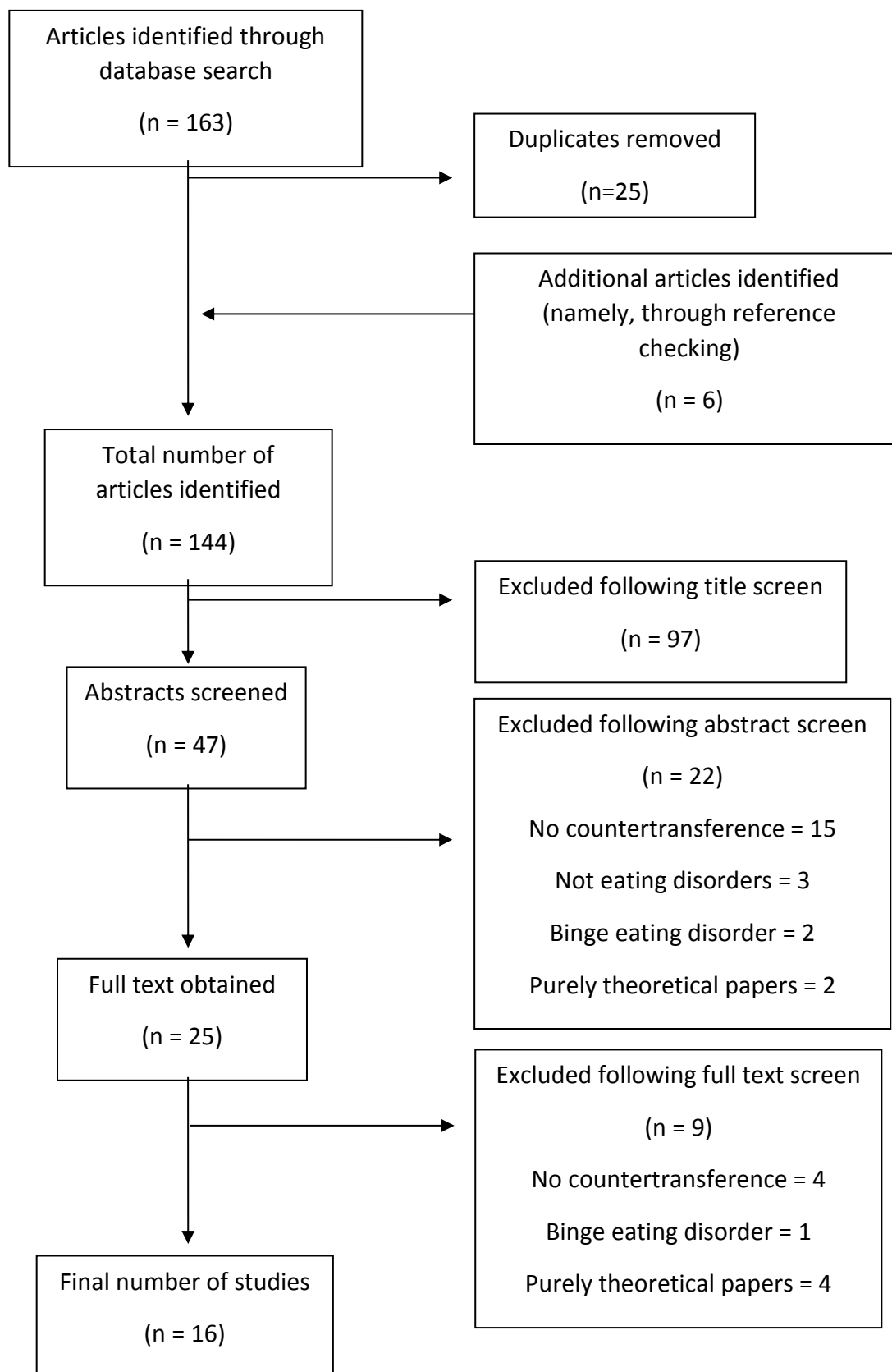
Figure 1 – Flow chart showing full search results

Table 1: Overview of papers included and main discussion points

Study number	Author	Design	Sample	Summary of paper
1	Conrad, N., Sloan, S. & Jedwabny, J. (1992)	Team case study	Staff working on inpatient unit. Number not specified.	Power struggles and issues of control noticed on inpatient unit, believed to be re-enactment of patient's experiences with family. Discusses steps taken by the team to address.
2	Daly, S. (2016)	Single case study	N=1	The therapist's own body can elicit feelings of envy and anger in patient, but can also be used to bring these feelings into therapeutic discussions.
3	Derenne, J. (2006)	Case study of own experience	N=1	Therapist began experiencing own body image issues and noticed increase in self-consciousness. Discussed similarities with patient's own experiences.
4	Franko, D. & Rolfe, S. (1996)	Mixed quantitative and qualitative survey	N=32	Asked clinicians to rate countertransference reactions to last patient seen with AN, BN and depression on 34 emotional subscales. Collapsed emotional reactions to give nine subscales. Found that 5 of 9 subscales differentiated patient group. Size of caseload and amount of experience affected extent of countertransference reactions. Factors felt to help with difficult countertransference reactions discussed.
5	Hudson, I. & Ritchie, S. (1999)	Group case study	Clinical material from group psychotherapy – number not specified.	Discussed countertransferences noticed by group facilitators, highlighting that these were reflections of group process occurring.
6	Hughes, P. (1997)	Case study	Clinical material of four patients presented	Patient may evoke a number of reactions in those around them due to wish to destroy/damage self.
7	Lowell, M. A. & Meader, L. L. (2005)	Case study	Two case studies presented	Discusses countertransference issues arising during therapy where the therapist is noticeably 'thin'. Uses case study of an underweight woman

with Anorexia and an overweight woman with Bulimia Nervosa to illustrate differences in countertransference.

Study number	Author	Design	Sample	Summary of paper
8	Palmer, A. (2015)	Qualitative interviews	N=5 dance/movement therapists	Countertransference common. Emotional and physical reactions noticed by therapists. Ways to manage countertransference discussed.
9	Rose, S. (2009)	Single case study	N=1	Presented countertransference experienced in therapy with client. Described process of other professionals unknowingly colluding with threat of breakdown to therapy.
10	Satir, D., Thompson-Brenner, H., Boisseau, C & Crisafulli, M. (2009)	Quantitative study using questionnaires	N=120 Surveyed multidisciplinary clinicians.	Study researching common countertransference reactions. Six patterns identified. Level of negative reactions low, but gender and job role of clinician, diagnosis of patient, length of time in treatment and personality pathology associated with different patterns of countertransference.
11	Shisslak, C., Gray, N. & Crago, M. (1989).	Quantitative study using questionnaires	N=71 Multidisciplinary clinicians surveyed.	Participants were classified into one of three groups based on their eating. Interactions found between previous history of eating and emotional reactions to working in eating disorder setting.
12	Strober, M. (2004)	Case study	Three case studies presented	Normality of experiencing negative countertransferences highlighted due to patient resistance to intervention. Importance of supervision and awareness of own characteristics discussed.
13	Swatton, A. (2011)	Single case study	N=1	Specific case study discussed. Attention paid to transference and countertransference reactions, with result being that nurse's ability to reason and responsiveness to psychological factors was compromised. Importance of medical professionals being aware of processes highlighted.
14	Vlahaki, I. (2012)	Single case study	N=1	Discussed somatic countertransference, which re-enacted patients own physical experiences of both bingeing/purging and her relationship with mother. Discussed using reactions to move therapy forward.

15	Walker, S. & Lloyd, C. (2011)	Qualitative interviews with study group	N=15 Participants had to hold professional qualification	Found negative countertransferences were common amongst professionals. Highlights inpatient settings and lack of training may result in particularly difficult countertransference experiences.
16	Warren, C., Crowly, M., Olivardia, R. & Schoen, A. (2009)	Mixed qualitative and quantitative study	N=43	Patients commenting on clinician appearance common. 70% felt personal views on food had changed, 54% thought eating had changed, & 71% felt awareness of appearance had increased. Importance of supervision highlighted.

4. Review

4.1 Description of papers

4.1.1 Overview

Five of the papers (2, 6, 9, 12 and 13) focused on clinicians working with patients with Anorexia, while three (5, 7 and 14) focused on those working with Bulimia. Two papers (4, 10) referred to clinicians working with different diagnoses, and six studies (1, 3, 8, 11, 15 and 16) did not specify which diagnoses clinicians worked with; however, all of these studies utilised clinicians working either in inpatient settings or made reference to clinicians working with patients with very low body weights. Nine of the papers (2, 3, 6, 7, 8, 9, 12, 13, 14) discussed the countertransference experienced by single therapists engaging in sessions with patients. Of these therapists, six were psychodynamically oriented therapists engaged in one to one therapy (2, 6, 7, 9, 12, 14), one (13) was a nurse seeing a patient for physical treatment, and one (3) was a junior doctor seeing patients for individual sessions as part of their psychiatry rotation. Two papers (5, 8) discussed the countertransference experienced by groups of clinicians made up of a singular profession – one (5) referred to two psychodynamically oriented therapists facilitating group therapy, while the other (8) looked at the experiences of dance/movement therapists. Finally, six papers (1, 4, 10, 11, 15, 16) discussed the experiences of multiple clinicians across a range of disciplines.

4.1.2 Design

Nine of the papers used qualitative methods. Of these, eight of the papers used single case studies (2, 3, 6, 7, 9, 12, 13, 14), one (1) used a team case study, one (5) provided a case study of a group process, and two (10, 11) used qualitative analysis on group responses to a study question. One (16) used a mixed methods approach and three (4, 10, 11) used quantitative research methods. Of those that used quantitative methods, all three used questionnaires to establish correlations.

4.2 Quality of studies

Three main types of study were used: qualitative (including case studies), non-randomised correlational quantitative and mixed-methods research. Therefore, the quality analysis tool developed by the National Collaborating Centre for Methods and Tools (2015) was used to assess the quality of papers presented, as this tool contains checklists for qualitative (including case study designs), quantitative and mixed methodologies (see Appendix A). Although this checklist does not result in absolute ratings of 'good' or 'bad' quality, the checklists contain several different questions for consideration which qualitatively indicate a study of a higher quality (such as consideration of data analysis, sampling strategies, response/follow up rates, dropout rates, etc.). Therefore, all studies used were compared to these checklists; however, a qualitatively poorer rating did not result in studies being excluded from the review, although aspects of studies which do not meet the criteria in the checklists have been noted. Due to differences in strengths and weaknesses and for clarity, the papers using case study designs and those using qualitative methods on groups of clinicians will be separated out.

4.2.1 Case studies

Strengths

Due to the focus on countertransference processes, all papers using case study designs (1, 2, 3, 5, 6, 7, 9, 12, 13, 14) studies gave proper, in-depth consideration as to how interactions with or the influence of the therapist/researcher may have influenced outcomes. Additionally, all case study designs gave sufficient consideration to the context in which the case study was taking place, highlighting the unique challenges of one-to-one sessions with patients experiencing eating disorders. It was felt as though the sources of information (i.e. the processes engaged in and material discussed during

therapy) were relevant to addressing the objectives/research questions of the papers – that is, the countertransference experienced by the therapist in question.

Weaknesses

One of the main weaknesses inherent in case study designs is that all findings are applicable only to the specific therapist with the specific patient described. No larger conclusions can be drawn about commonalities in processes experienced by therapists on the bases of case studies taken in isolation. Therefore, when considered independently, the generalisability of the case study designs are weak; however, repeated case studies by different clinicians describing the same countertransferences may begin to create a picture of commonality required to justify more in-depth research. Furthermore, most of the case studies in question were written by psychodynamically oriented psychotherapists engaging on one-to-one sessions with patients (2, 6, 7, 9, 12, 14), which represents a very limited sample.

Additionally, there is limited description as to how data has been analysed in all case study designs presented. There is no mention of process notes, outcomes, tapings of sessions and so on – only sections of material and the interpretation of these. Therefore, the reliability and validity of material discussed cannot be effectively evaluated.

4.2.2 Qualitative studies

Strengths

Both of the papers (8, 15) used interviews to gather the views of clinicians working with clients diagnosed with eating disorders – one of the papers (8) conducted individual interviews, while the other (15) used a focus group. Both papers clearly stated that interviews were audiotaped and gave an overview of the questions/topic areas discussed with individuals taking part in the studies. One paper

(8) talked extensively about the process of validation, including the use of epochè (that is, the separating off of researchers own opinions). Both papers thoroughly described the process of analysis, including the pre-established procedural stages for data analysis utilised. Both papers gave some consideration to the impact that the researcher may have had on the results of the interviews.

Weaknesses

Neither paper gave consideration as to why participants may have been motivated to take part in the interview process, or why participants may have declined to be included. One paper (15) discussed the sampling technique used, highlighting that all participants were recruited from the same hospital. Therefore generalisability to other settings may be limited. Additionally, one of the papers (8) used a relatively small sample of five participants, all of who were from the same professional background of dance/movement therapists. This may mean that the ability to extrapolate the experience of this professional group to other clinicians is limited.

4.2.3 Quantitative studies

Strengths

All of the studies (4, 10, 11) used questionnaires to establish the correlation between clinicians working with patients with eating disorders and emotional responses/experiences. All of the studies gave an overview of the sampling strategy used, which was appropriate for the question, with two of the studies (4, 11) including clinicians from a variety of professional backgrounds. Two papers (10, 11) explicitly stated that research was exploratory; therefore, the methods employed were thought to be appropriate. The completion rate for one study (10) was satisfactory, with a completion rate of 65%. Additionally, both studies (4, 10) requesting that clinicians think about their reactions in relation to patients attempted to ensure the random selection clinical material by requesting that clinicians use

the last patient seen who meets the specified diagnostic criteria. This was an attempt to control for selection bias that may have been present otherwise – for example, to stop clinicians from choosing a preferred patient, or a particularly problematic patient.

Weaknesses

Two of the studies (4, 11) had a low completion rate, with only 46% and 41% of clinicians respectively completing and returning the questionnaire. Although both studies state that this is within normal parameters of previous studies, this is still low according to the checklist employed. Additionally, one of the studies (10) used a relatively limited sample of only psychiatrists and psychologists, while the other study (11) recruited participants from those attending a conference on eating disorders. This may mean that key members of the multi-disciplinary team who may be less likely to attend conferences (e.g. health care assistants/support workers) may have been missed. The final study (4) recruited participants who had identified themselves as being ‘experts’ in the area of eating disorders, which may indicate that once again, those clinicians such as health care assistants may have been excluded from research. Additionally, by recruiting from a pool of those classifying themselves as ‘experts’, the representativeness of the sample may have been compromised.

Furthermore, as all studies were exploratory in nature, they all used self-developed questionnaires which had not been tested for validity or reliability. This was somewhat unavoidable given the paucity of research in this area; however, the lack of rigorous testing of questionnaire material may result in the reliability of results being somewhat limited. This is especially true when considering that two of the studies sought to generate a scale of reactions experienced (4, 10) while the other categorised participants based on their eating habits (11). These categorical dimensions were not subject to rigorous analysis, and therefore must be considered with caution. Finally, one of the studies (4) stated that some respondents did not complete all scales – however the number of incomplete scales

received was not reported and no consideration was given as to why respondents may or may not have omitted some scales. Therefore there may be some confounding variables which were not fully considered or controlled for present within this study. Finally, in asking therapists to think of the last patient seen (4, 10) rather than asking clinicians to think more broadly about the general reactions experience, the conclusions drawn may only be relevant to that particular patient, rather than being indicative of broader countertransference processes.

4.2.4 Mixed method approaches

Strengths

The study employing a mixed methods approach (16) was clear as to the rationale in using a mixed qualitative and quantitative approach, with the methods selected being suitable to answer the research question. The data was brought together in a coherent analysis, with the researcher and two others coding the qualitative data independently before meeting to check the congruence of codes.

Weaknesses

Although the data was integrated coherently, there was no mention of when this integration occurred. Additionally, no consideration was given to the limitations of the mixed methods approach. Furthermore, all participants were once again attendees at an eating disorder conference, with all holding professional qualifications. Once more this induces a confounding variable, in that the subject pool consisted entirely of those motivated and able to attend a conference. No health care assistants/support workers took part in this research, and only a very small proportion of nurses were present in the sample.

4.3 Countertransference in staff working in eating disorder settings

4.3.1 Emotional Countertransference

Eleven of the papers discussed the emotional effect that working with patients with eating disorders had on clinicians (1, 4, 5, 6, 8, 9, 10, 12, 13, 14, 15), with all of these papers noting at that at least some negative emotional countertransference was common. Two papers (5, 14) spoke about therapists feeling in some way 'controlled', with one (5) highlighting how therapists may feel as though they cannot give enough or, conversely, what they are providing is wrong. Additionally, therapists may feel marginalised (5) or may feel as though the patient is in charge (14).

Anger was a common reaction, noted by six of the papers (5, 6, 8, 10, 12, 15). One paper (5) discussed the ways in which behaviour perceived as coercive may result in the pull to give 'special treatment'. Subsequent resistance to treatment was thought to be the reason for resulting anger (5), while this coercive behaviour and subsequent rejection of care could often lead to power struggles between patients and their therapists (1). Frustration (4, 8, 10, 12, 15), concern (6, 8), envy/competitiveness (5, 13) and responsibility (5, 13) were all commonly noted and discussed. Additionally, two papers (9, 10) discussed how feelings of boredom were common, noting that this may be a reflection of the detachment that patients feel towards therapy and potentially to emotional states in general (9). Finally, two papers (4, 10) specifically discussed feelings of 'caring/connectedness'; however, both papers noted that these 'warm' feelings could be reduced when the behaviour of patients and the negative countertransferences experienced by staff became more intense. These difficult experiences were summed up by one paper (12), which noted that negative countertransferences were commonplace amongst therapists working in eating disorder settings, and can often result in the desire to be 'free' from the client.

4.3.2 Physical countertransference

Two papers specifically discussed the physical countertransferences experienced by therapists (8, 14). One paper (8) spoke extensively about physical sensations of anxiety, which commonly mirror the experiences of the patients being treated for eating disorders. Additionally, discomfort and tension within the therapist's body and a strange sensation of 'fluttering' in the chest were reported by the dance/movement therapists interviewed (8). The other paper (14) highlighted how the therapist in question began to feel 'riveted' on their own bodily reaction in a similar manner to which the patient was fixated on their own bodily reactions. The therapist noted that sessions often left him with a feeling of being 'force-fed' and 'uncomfortable full', which were reflected on given that the patient in question was one being treated for Bulimia Nervosa.

4.3.3 Impact on clinician's perception of their body

In total, six of the papers discussed the impact that working with patients with eating disorders had on clinician perceptions on their bodies (2, 3, 7, 11, 15, 16). Body image issues (3), including clinicians feeling more aware of their bodies (2, 11, 15, 16), feeling more self conscious (2, 3, 7, 11, 15), increasing exercise (3), and experiencing bodily distortions (7) were all noted. Two papers (2, 16) discussed the feeling of 'being watched' by patients, almost as if patients were monitoring or evaluating the bodies of staff, which may contribute to the increase in feelings of 'self-consciousness'. Indeed, one paper (16) specifically asked clinicians whether their patients ever commented on their (clinician's) bodies. Not only did clinicians generally agree that this was common, but they highlighted that approximately twenty five percent of their patients had made a comment about their (clinician's) appearance. Although the majority of these comments were perceived as compliments (86%), thirteen percent of comments were regarded as criticisms, with the vast majority of these being due to the weight, height or age of the clinician. Additionally, two papers (11, 16) noted that clinicians felt as though they were more aware of the food that they were eating, with one paper (16) specifically

stating that clinicians surveyed felt as though their eating habits had changed. One paper (16) noted that twenty five percent felt as though they were engaging in more disordered eating since working in eating disorder settings, with seven percent noting that they had engaged in disordered eating behaviour immediately after a session. However, that is not to say that all of these reactions were negative. Although feelings of shame (7, 15) were noted, several of the papers highlighted that these perceived changes may have been positive (7, 11 15), with a particular emphasis on the fact that many clinicians felt as though they were eating healthier as a result of their work with patients with eating disorders (11). Additionally, one paper (2) noted that the impact that working in eating disorder setting may have on the clinician's perception of their body may differ due to their own pre-existing perceptions of self, as well as how 'desired' their body type may be by the client group. 'Thin' therapists may be more likely to feel pride than disgust at their own bodies (2), which may mediate the intensity of negative changes to their perception of their own bodies and eating habits.

4.3.4 Countertransference and the impact on team processes

One paper looked specifically at the impact that countertransference had on the dynamics of the team (1). On arrival at the inpatient service, the author noted that staff and patients both seemed 'out of control'. Power struggles between patients and their eating disorders, as well as patients and staff, were mirrored in power struggles between different members of staff – most commonly, between different disciplines of staff, such as nurses and the psychiatrists. Additionally, 'splits' within the staff team were relatively commonplace, which seemed to make treatment of patients more difficult due to conflicts and difficulty finding a consensus around the best course of treatment.

4.3.5 Difference in countertransference and diagnosis

Two papers (4, 10) looked specifically at the impact that different diagnoses may have on the countertransference experienced by clinicians working with patients with eating disorders. The first paper (4) found that those with a diagnosis of Anorexia Nervosa elicited more feelings of frustration and hopelessness and fewer feelings of connectedness and successfulness than those with a diagnosis of Bulimia Nervosa. However, feelings of engagement were similar in clinicians working with patients with Anorexia Nervosa and Bulimia Nervosa. Interestingly, these were mediated by caseload size and the level of experience that clinicians had (both general level of experience as therapists and experience specifically within eating disorder settings), with a larger case load and less experience associated with more negative countertransferences. Conversely, the other paper in question (10) asked clinicians about working with those with a diagnosis of Anorexia Nervosa, Bulimia Nervosa or Eating Disorder Not Otherwise Specified (EDNOS), finding that Anorexia was associated with more feelings of warmth/competence than the other two diagnoses and fewer feelings of failing/incompetence than EDNOS. However, the paper highlighted that personality pathology (i.e. a pattern of interaction consistent with a diagnostic label of personality disorder) may mediate this, with significant personality pathology associated with increased feelings of anger/ frustration and fewer feelings of warmth/competence.

4.3.6 Management of countertransference reactions

In total, nine of the papers (1, 3, 4, 6, 8, 12, 13, 15, 16) suggested ways in which countertransference could be managed. The importance of supervision was particularly highlighted (8, 12, 16), with one paper (12) in particular stressing the importance of supervision being a place for 'emotional discharge'. Three papers (6, 8, 13) highlighted the need for clinicians to remain aware of their feelings 'in the moment' and to be able to name the difficult reactions that they may experience. Although this may be manageable and relatively easy for therapists trained in psychodynamic or psychoanalytic therapy,

other members within the team who may not have this theoretical grounding may find this problematic (13). Therefore, it is important that *all* team members are encouraged to pay attention to countertransference processes, including those who may be working from a more medically oriented model (13). One paper (15) stressed how inpatient setting may be especially problematic, due to the more intense resistance typically exhibited by patients coupled with the effects that starvation have on the brain (15). Where this begins to impact the whole team and factors such as splitting, power conflicts or lack of control become more noticeable, implementation of clear expectations, guidelines and boundaries may be helpful in regaining balance and control (1). Lack of training (15) and inexperience (4) were also highlighted as common reasons for clinicians experiencing particularly negative countertransference. Smaller caseloads, particularly for staff with less experience working with eating disorders and in general (4), were correlated with significantly fewer countertransference reactions. Additionally, investment in training for staff at all levels (15) was seen as important by staff surveyed in helping to manage negative reactions. Finally, general awareness of the self, including pre-existing body image issues (2, 15), personality characteristics (12), and ability to remain compassionate towards the self in the context of difficult experiences (8) were seen to be important qualities for staff to analyse and embrace, either independently or in supervision (8).

5. DISCUSSION

5.1 Summary of findings

Generally speaking, there is a paucity of literature into the impact that countertransference has on staff working in eating disorder settings. The few articles which do exist are generally poorer quality – they primarily focus on therapists, with single case studies seemingly written in retrospect the most common method of disseminating ideas and results. Those which have sought to establish common countertransference using groups of participants, either qualitatively or quantitatively, have relied

heavily on questionnaires, or have generally recruited from potentially homogenous sources. However, despite the relatively poor quality of many of the papers, the majority of published research has highlighted that staff may be deeply affected when working with patients with eating disorders. Many of the experiences are negative, with anger, frustration, increased self-consciousness, conflict within teams and physical discomfort all being reported. In particular, staff who are relatively inexperienced or those who lack training appear to report the most significantly distressing and difficult countertransference reactions, with high case loads being linked to more intense countertransference. There is some preliminary evidence that diagnosis may be linked to differences in countertransference; however this research is extremely limited and conflicting. Generally, there are similarities in the suggestions as to how best to manage difficult and intense reactions, with supervision seemingly the most commonly cited suggestion. Being encouraged to be aware of emotional reactions, the space to consider what these reactions mean and the vocabulary to name countertransference may all help clinicians understand and manage what may be intense and potentially very personally distressing experiences. However, it is important to note that not all of the reactions experienced by clinicians are negative, with some suggestions that working in eating disorder settings resulted in healthier food choices, increased activity and even some pride about body image.

5.2 Implications for clinical practice

Despite the paucity of research, there does appear to be a general consensus that working with patients with eating disorders can result in clinicians experiencing a number of negative reactions emotionally, physically, and with regards to their body image. This may have an impact on treatment; clinicians who experience anger, envy, frustration and inadequacy in relation to their patients may find it harder to build a therapeutic relationship and to engage meaningfully with the patients who elicit the strongest countertransference. Clinicians feeling as though their bodies are under scrutiny, or

those who receive direct comments about their appearance, may become more aware of their bodies which may in itself result in increased negative feelings towards their patients. Additionally, there is a possibility that staff retention may be affected, as it is plausible that staff may be reluctant to remain in an environment in which they experience a high degree of negative emotions while simultaneously attempting to treat patients who are ambivalent, resistant to treatment and negative about input received (Vitousek, Watson & Wilson, 1998; Williamson, Muller, Reas & Thaw, 1999). Indeed, previous research has highlighted that being overweight was a particular risk factor for burnout when working in eating disorder settings (Warren, Schafer, Crowley & Olivardia, 2013), implying that there is some substance to the idea that clinicians may experience an increase in self consciousness in relation to their bodies.

High case loads were also implicated in an increase in negative countertransference. Although theoretically having a higher ratio of clinicians to patients to keep caseloads low seems like a logical idea given the emotional intensity involved in working with patients with eating disorders, there are questions as to how realistic this is in the current climate of reduced funding and increased pressure to make efficiency savings which is characteristic of the NHS. Although the government announced an extra one hundred and fifty million pounds would be directed towards eating disorder services over the next five years (Autumn Statement, 2014), this comes with specific waiting list targets of assessment within four weeks of referral, which is likely to mean increased pressure on clinicians to assess and treat as many patients as possible in a short time frame.

Although inpatient services were highlighted as being particularly difficult in terms of the negative impact on staff, this seems somewhat logical due to the inference that those requiring inpatient admissions are more at risk physically from their eating disorder, which may also imply that their eating disorder is more established or severe in pathology (having lost enough weight that they are

physically compromised). Therefore, staff working in inpatient settings may find countertransference particularly problematic. However, co-morbidity of other complex mental health conditions, including suicidal ideation and self-harm (Braun, Sunday & Halmi, 1994; Harris & Barraclough, 1998), coupled with the need for round-the-clock supervision of patients may result in increased time constraints, which are often inherent with working on an inpatient ward. Therefore, finding time to adequately analyse and consider the countertransference of staff may be problematic, resulting in a need that goes broadly unmet. The same could be said for finding adequate time for good supervision, which was consistently flagged as being one of the ways to understand and process negative countertransference. Previous research has suggested that supervision within an inpatient setting may be sparse, and when analysed, meetings classed as clinical supervision often do not meet the criteria of supervision (Cleary & Freeman, 2005). As such, one of arguably the most important processes in which staff are supported to manage their difficult experiences may often be missing or inadequate in inpatient settings.

5.3 Implications for research

Research into the ways in which staff may be impacted by their work in eating disorders is still a relatively new field, with a paucity of studies. Those studies which have been conducted are of generally poor quality, using small samples of limited professional groups or relying on single case studies. Despite the fact that studies have generally tended to find similar countertransference reactions in clinicians, the ability to generalise these findings is still extremely limited. Therefore, further good quality research is needed in general to begin to establish a fuller picture of how countertransference may impact staff working with those with eating disorders. Additionally, while the focus on purely descriptive processes is necessary for research at its genesis, it leaves little room for

inference as to *why* these processes may be occurring. Although we may be able to call these influences ‘countertransference’, this is simply a technical term generated from one school of psychological theory, and it may be a term that is only understandable to those who have some knowledge of psychodynamic or psychoanalytic processes. Therefore, this terminology may be of limited use to other members of the multidisciplinary team who have not had this grounding, and it may be useful to explore exactly how staff make senses of these experiences. Indeed, previous research has focused almost exclusively on therapists and psychiatrists, who are the most likely to have some theoretical knowledge about countertransference and may be comfortable talking about the impact in these terms. However, other members of the team without this grounding may find this terminology confusing or unclear. Therefore, if other members of the team are included in future research, broadening out the terminology so that it may be understood and embraced by all members of the clinical team may be helpful. An additional problem with this limited subject pool is the fact that therapists and psychiatrists may be the clinicians who have the most awareness of countertransference processes. This awareness may be protective, as it may allow clinicians to label experiences (especially those which may be experienced as negative) as being a by-product of therapeutic processes rather than being generated through internal changes. However, those clinicians without this grounding may lack the ability to label these experiences as being due to countertransference, and therefore may find these experiences more personally distressing. Although there has been some inclusion of social workers in previous research, nurses have only been included in an extremely limited number of studies, and healthcare assistants or support workers have been excluded entirely. As a wide range of professionals are involved in the support, care and recovery of those with eating disorders, it seems strange that research has not reflected this. Future research may therefore wish to broaden inclusion criteria to assess the impact that countertransference has on a wider range of professionals, and whether there is a difference in the extent to which different

professionals are impacted by their work. Additionally, supervision has been suggested as a method to manage countertransference processes; however what supervision looks like may differ vastly between professional groups or between individuals (Cleary & Freeman, 2005). Future research may wish to focus specifically on the impact that supervision has on clinicians' ability to manage the impact of working in such an environment.

More broadly speaking, the vast majority of existing research uses the term 'countertransference' to discuss the impact that working within eating disorder services may have on staff. Generally, the established nature of the term countertransference within psychodynamic and psychoanalytic theory results in a distinct space for this research to sit, giving rise to consideration for how clinical work may impact clinicians which may otherwise go unconsidered or unpublished. This also had the added benefit of normalising difficult feelings and experiences for clinicians, thereby allowing consideration and discussion. However, the broadest definition of countertransference employed by totalists such as Racker (1968) suggests that it is a clinician's response to a patient's transference and needs, whether conscious or unconscious. Within this definition there is no consideration for other factors which may impact the clinician. Therefore, continuing to framing the impact of eating disorder work solely as 'countertransference' may restrict our understanding of these processes and why or how they occur to a singular, patient-driven explanation. A broader, more general consideration of how and why eating disorder environments may have such a significant impact on clinicians may therefore enable a broader consideration of these processes, resulting in a more comprehensive explanation.

There is some indication that inpatient working may have a more significant impact on clinicians than outpatient or community work, due to the complexity associated with individuals with eating disorders who require hospitalisation. An extension of this may be that more intense inpatient working – for example, in hospitals which use nasogastric tube feeding under restraint for those under involuntary

admission – may induce significantly more negative countertransference than working with those entering hospital voluntarily or those being treated within the community. Research may wish to look specifically at the ways in which different settings may intensify countertransference.

Finally, there is a growing body of evidence that working in an eating disorder setting may result in changes to clinicians' body image and eating habits, with some conflicting evidence as to whether these changes are perceived as harmful or helpful/healthy. This may have strong implications for the mental health and wellbeing of staff working in these settings – if the changes are indeed experienced as harmful, with clinicians experiencing increased bodily dissatisfaction and changes to their eating habits, then the ethical implications of staff working in intense environments without close monitoring, supervision, and discussion of the potential changes that they may experience become rather worrying. Further research is needed into whether these changes do occur, how staff may experience these, and what sense they may make of any noticeable changes.

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Section B: “Food for thought and thoughts of food”: A grounded theory analysis of the impact of inpatient eating disorder environments on staff body image and eating habits

Word count: 7994 + 290

7. Abstract

Objective: Research into how staff working in eating disorder setting may be affected by their work is still a reasonably new area, with many previous studies relying on homogenous groups for recruitment or utilising survey based methodologies. Therefore, this study used a grounded theory approach to construct a theory of changes to body image, perceptions of food and diet experienced by clinicians, how these changes are experienced or made sense of, and what factors may contribute to these changes.

Method: Thirteen members of staff were interviewed about their body image and eating habits before and since working in eating disorder settings. Participants were drawn from a range of different staff groups. Interviews were analysed using grounded theory to develop a theoretical model of why changes to body image and eating habits may occur.

Results: Three core categories were defined, and a theoretical model was postulated in which pre-existing body image and ideas of food, the work environment, access to support, the impact of patients themselves and promotion of chaotic eating through the work itself all interplay to create change. Individual differences in management and the “personalised meaning” ascribed to these changes mediate how these changes are labelled and managed. Implications for future research and clinical practice are discussed.

Key words: Eating Disorders, staff, countertransference, grounded theory, body image

8. Introduction

The concept of eating disorders is not a new one. Descriptions of eating disorders can be found as far back as the 12th and 13th century BC, with the earliest medical case studies being attributed to Richard Morton in 1689 (Pearce, 2004). However, it was not until 1873 with the publication of Gull's seminal case studies of Anorexia that the term 'Anorexia Nervosa' was coined (Gull, 1873). Since then, our knowledge of eating disorders has grown exponentially, with documented cases also multiplying in a similarly rapid way. However, despite a proliferation of research into understanding the theoretical biological, psychological and social factors which may contribute to an individual developing an eating disorder, research has only very recently begun to focus on how staff working with individuals diagnosed with eating disorders may be affected by their work.

Although understanding the impact that working with patients has on staff is a relatively new area of research in general, it is not a new concept in psychological theory. Indeed, one of the central tenets of psychoanalytic theory is that of countertransference, which was introduced by Freud in 1910 – that is, the influence that the patient has on the therapist due to the therapist's own unconscious feelings (Freud, 1910). This definition has been subject to some debate over the years, with Freud and his fellow 'classicists' favouring the original, narrower definition, while 'totalists' have tended to broaden this to encapsulate all of the reactions that the therapist may have towards the patient, whether conscious or unconscious (Racker, 1968). In any event, there have been multiple case studies throughout the years which have highlighted the impact that psychological therapy in general can have on the therapist – from the therapist experiencing hate (Maltzberger & Buie, 1974), to hopelessness (Richards, 2000) and even vicarious traumatisation (Pearlman & Saakvitne, 1995). Therapists can be left feeling inadequate (Epstein, 1987) or lost (Searles, 1987), and

countertransference that is improperly analysed or contained may result in the therapist acting inappropriately (Searles, 1987; Racker, 1957).

With so many accounts of the impact that countertransference may have on therapists, it is only natural that focus has shifted specifically to those working in eating disorder settings. There has been a growing recognition that recovery from an eating disorder does not often happen in isolation, with Goldberg (1986) positing that research had “ignored an extremely significant part of the process – the practitioner” (p. 25).

Generally speaking, research into this area has found many staff reactions which are similar to those which have been previously noted in relation to staff working with other mental health conditions, including anger (Hudson, & Ritchie, 1999), frustration (Franko, & Rolfe, 1996; Palmer, 2015), and inadequacy (Hudson, & Ritchie, 1999). Interestingly, however, there have also been many studies citing envy and competitiveness (Hudson, & Ritchie, 1999; Swatton, 2011), which remain relatively uncommon when studying staff reactions to working with patients with other diagnoses. One explanation for this is that western societal ideas strongly encourage ‘thinness’, equating it with ‘wealth’, ‘beauty’ and ‘success’.

Simultaneously, ‘fatness’ is discouraged, and often equated with being ‘unattractive’ and ‘lazy’. This lends a certain amount of social acceptability to eating disorders, with the boundary between being ‘desirably thin’ and ‘too thin’ being extremely blurred and moveable (Bloom et al 1994; Bloom 2002; Rodin, Silberstein & Striegel-Moore, 1985).

Additionally, the propensity for bodily comparisons (which may be self-to-self or self-to-other) often noted in those with eating disorders means that the body is often the subject of focus (Hamel, Zaitsoff, Taylor, Menna & Le Grange, 2012). Frankenburg (1984) noted that therapists’ bodies are often scrutinised by their clients, with clients often making comparisons between themselves and the therapist. Therapists have reported noticing this

scrutiny, with feelings of being 'watched' and 'evaluated' commonly described (Daly, 2012; Warren, Crowly, Olivardia & Schoen, 2009). In addition to just 'feeling' as though they are being watched, staff have also found themselves in the uncomfortable position of having their bodies directly commented on. In a survey of multidisciplinary staff working with clients with eating disorders, the majority of clinicians responded that patients had directly commented on their appearance (Warren et al., 2009). Roughly 20% of clinicians surveyed also noted that they had experienced difficulties within the therapeutic relationship, most notably around frustration with clients and managing countertransference. Warren et al. suggested that this increased scrutiny of the therapist's body and the ensuing countertransference experienced could potentially influence the way the therapist views their own eating and appearance (Warren et al., 2009).

However, research specifically into the ways in which clinician eating and appearance may be influenced by working with clients with eating disorder diagnoses has been extremely limited. Although there have been some reflective case studies which highlight the increased awareness that clinicians feel towards their own bodies (Daly, 2012; Derenne, 2006; Lowell & Meader, 2005), these studies are extremely limited in their generalisability. Overall, there is a general paucity of studies using larger samples of clinicians to draw overarching conclusions about the impact that eating disorder work may have on clinician body image and eating habits. Nonetheless, those studies which have used larger samples have resulted in somewhat conflicting results. For example, qualitative interviews with clinicians working in eating disorder settings revealed that clinicians often felt more aware of their body shape and size, and reported feeling 'huge' or 'big' when surrounded by 'tiny' and 'delicate' patients (Walker & Lloyd, 2011). These feelings of being 'larger' resulted in some of the clinicians feeling increasingly dissatisfied with their bodies, and resulted in the

idea that clinician confidence and bodily security were highly important for anyone working in eating disorder settings. Additionally, a theme to emerge from interviews was that previous poor body image experienced by clinicians could be 'awoken' through working in eating disorder settings.

Despite this, a similar finding linking previous body satisfaction to the extent to which clinicians notice changes to their body image and eating habits was noted in a study by Shisslak, Gray and Crago (1989). During this study, clinicians were surveyed, with a large proportion reporting increased awareness of food and their appearance, resulting in changes to body image and eating habits. This degree of change was linked to previous eating history ('normal', 'binging', or 'anorectic/binging with purging symptoms'), with those in the 'binging' or 'anorectic/binging with purging symptoms' categories reporting a greater awareness of food since working in eating disorder settings. Interestingly, clinicians reported that they felt as though these were generally positive changes, with the majority of those affected reporting that they felt as though they were now eating healthier food since beginning work in the field.

This potential to see changes to eating habits in a positive way was reflected in a further study using surveys by Warren et al. (2009). Seventy percent of clinicians reported feeling as though their eating perceptions of food had changed, while a 54% felt as though their actual eating habits had changed. Of those reporting changes, the majority felt as though they were positive changes, with participants feeling as though they were making healthier food choices, taking a greater enjoyment from eating food and eating more mindfully.

Conversely, twenty five percent felt as though they were engaging in more disordered eating since working in eating disorder settings, with seven percent noting that they had engaged in disordered eating behaviour immediately after a session.

Although these studies sought to explore whether clinicians were affected by their work in eating disorder settings, they did not consider how clinicians may make sense of these changes. Additionally, all of the aforementioned studies tended to use the psychoanalytic/psychodynamic view of 'countertransference' to explain the changes. As the term 'countertransference' is simply terminology from one school of psychological or psychotherapeutic theory, simply accepting and applying this term to the impact on clinicians may be rather narrowing, as it may only be understandable or considered by those who work in a psychodynamic or psychoanalytic way. Additionally, at its broadest definition, the term 'countertransference' considers only the reactions that a clinician may have in response to a patient's transference and needs (Racket, 1968). Other factors, such as the environment itself, clinician background and cultural ideals and pre-existing experiences of food/body image, may not be considered in this definition, leaving a much narrower (and potentially insufficient) explanation of why clinicians may be affected by their work.

Therefore, Swancott (2012) used Independent Phenomenological Analysis (IPA) to try to understand how clinical psychologists working in an eating disorder environment understood their eating and any changes to their eating habits. Although clinicians reported some behaviours that may be interpreted as being a result of working in an eating disorder environment (e.g. increased awareness of calorie content of food and vigorous exercise), clinicians generally reported feeling reasonably unaffected by their work. This resulted in the researcher concluding that clinicians may be consciously or unconsciously justifying or minimising changes to their perceptions of their body and food, emphasising the need for further research into this area.

Although there is some preliminary evidence to suggest that clinicians may experience changes to their body image and eating habits after beginning to work in eating disorder

settings, it remains unclear whether these changes may be experienced as positive or negative by the individual. Studies have tended to be of relatively poor quality, using homogenous samples which are restricted to those holding professional qualifications (Shisslak et al., 1989; Warren et al., 2009; Walker & Lloyd, 2011), those attending a professional-level conference (Shisslak et al., 1989; Warren et al., 2009; Swancott, 2012), a single hospital team (Walker & Lloyd, 2011), or a single professional group (Swancott, 2012), with the result being that all existing studies have utilised extremely homogenous groups which have excluded entire job roles, such as healthcare assistants/support workers. Existing studies have heavily relied on single case designs (Daly, 2012; Derenne, 2006; Lowell & Meader, 2005) or on surveys (Shisslak et al, 1989; Warren et al, 2009), both of which limit the generalisability of findings and which cannot be used to infer causation. Finally, the vast majority of existing research has employed the construct of ‘countertransference’ to understand and interpret the processes which result in clinicians feeling affected by their work. This implies that any impact of work in eating disorder environments is driven by patient transference and conscious or unconscious need. Limited attention has been given to exactly how clinicians may experience and make sense of any change, along with how other factors may impact clinician experience (such as culture, environmental factors, and so on). The only study found which attempted to move away from the framework of countertransference and take a broader view of the impact of the work on clinicians concluded that participants were either consciously or unconsciously being untruthful in their responses (Swancott, 2012). Therefore, this study sought address the paucity and poor quality of existing literature by exploring the following questions:

- 4. Do clinicians working in inpatient eating disorder setting experience changes to their body image, eating habits and perceptions of food (either positive or negative)?**
- 5. How do clinicians experience and make sense of these changes?**
- 6. What do clinicians feel contributes to these changes, and what helps clinicians to cope?**

8. Method

8.1 Design

The study used a qualitative approach, using a grounded theory approach. Grounded theory was selected, as currently there is very little information focusing on how working in eating disorder settings may impact clinicians, with the majority of established research being descriptive in nature. Therefore, grounded theory may be beneficial to begin constructing a theory of how working in an eating disorder setting may influence staff body image and eating habits. The Strauss and Corbin (1998) version of grounded theory was used, due to the focus on validation, abduction and the greater emphasis on broader environmental factors. Additionally, it has been suggested that the account of grounded theory proposed by Strauss and Corbin (1998) is more consistent with postpositivism and critical realism (Charmaz, 2000), which fits with the epistemology of the researcher.

8.2 Participants

In total, thirteen people participated in the study, of which eleven were female. Participants were all members of staff working at one of two private inpatient adolescent Eating Disorder hospitals. Five participants were between the ages of 20-24 years old, seven were between 25-29 years old and one was between 30-34 years old. In terms of ethnicity, five reported that they were English/Northern Irish/Scottish/Welsh, one reported that they were Irish, and two reported that they were white – other. Three reported that they were African, and two reported that they were black – other. Nine of the participants were therapeutic care workers/healthcare assistants for at least a portion of their week, with three of these also being assistant psychologists part of the time. One was a qualified nurse,

while the remaining participants had other job roles within the team. For confidentiality purposes, these jobs will not be reported, as it is likely that participants could be identified. Most participants were reasonably new to eating disorder work, with seven working in this environment between 0-1 years. Five has been working in eating disorders from 1-2 years, and one between 3-5 years. Finally, five participants said that they had previous histories of disordered eating. Of these, two had prior diagnoses of anorexia nervosa, one had a prior diagnosis of Eating Disorder Not Otherwise Specified (EDNOS), and two disclosed prior histories of restriction without receiving a formal diagnosis of eating disorder.

. Initially, a minimum of six months of experience of eating disorder-related work was required; however this was subsequently removed following consultation with both staff and supervisors.

Participation was based on opportunistic sampling. The lead researcher attended three staff meetings and the information sheet was circulated, with staff who were interested in taking part encouraged to make contact with the lead researcher to express any interest and find out more. As an incentive for taking part, all staff who participated were entered into a draw to win one of three £10 vouchers of their choice.

8.3 Procedure

An email with the study information sheet (see Appendix B) was circulated to all staff by the lead clinical psychologist for the service and external supervisor for this project.

Additionally, the lead researcher attended the research team meeting, a psychology team meeting and a ward meeting to discuss the research being conducted, with the request that this be cascaded to team members. Hard copies of the information sheet were also

provided, which contained the email address of the lead researcher. No deception was used during this study, so all participants were informed of the nature of the study and what was being explored.

If participants made contact to express interest, initially the standard reply was to re-send the information sheet, request that the participants read through to check that they were informed of the study, and to invite the participants to ask any questions. Once participants confirmed that they had read the information sheet thoroughly and all questions were answered, participants were asked for times and dates that suited them to meet individually with the lead researcher to complete the interview.

All face-to-face interviews took place in a quiet therapy room within the private hospital.

Three of the participants were unable to take part in face-to-face interviews due to issues with either being unable to get time away from the wards to take part, or due to a strong desire for peers to remain unaware that they had been interviewed for the project.

However, as these three participants were particularly keen to participate, after discussion with the external supervisor it was decided to conduct the interviews by telephone. These participants received a copy of the consent form and demographic sheet prior to interview (Appendix C and D respectively).

At the beginning of the interview, consent, confidentiality, right to withdraw and the anonymising of data were all explained. Permission was sought to audio record the interviews and participants were given another opportunity to ask any questions or raise any concerns that they may have. Face-to-face participants were then asked to complete the consent form and demographic sheet, and those being interviewed via telephone were read the consent form and asked for verbal consent, with the written consent to be provided immediately after the telephone interview. Providing that participants were happy

to continue, the interview was then conducted, using the interview schedule provided in Appendix E. General areas of discussion were past experiences (including questions on body image and eating habits), adult experiences (including body image and eating habits), experiences since working in inpatient eating disorders (including any changes to body image/eating habits and experiences of patients), experience of building therapeutic relationships and any notable protective or risk factors. All interviews were recorded using a Dictaphone. Interviews varied in length, but were between approximately 40 minutes to an hour in length, depending on the amount of information that participants had to share. Following the interview, participants were once again asked whether they had any questions. They were then given a full debrief about the project, including the ideas being explored and the expected completion and submission dates. Participants were then asked about how they experienced the interview, whether it raised anything difficult for them and whether they had any concerns about the impact that the interview had on them. One participant raised that it made them realise how angry they were at the lack of support received from their employer, which was discussed, with the participant being directed to use clinical supervision to talk about this. No other participants raised any concerns. Finally, participants were provided with a contact sheet of useful phone numbers, should they be worried about the mood, body image or eating habits of themselves or others (Appendix F). Interviews were immediately transferred from the Dictaphone to an encrypted, password protected USB stick and were re-named with a random participant number from 1-20. Participants were given this number and advised to quote this should they wish to withdraw from the project. For those being interviewed by telephone, both the list of telephone numbers and the participant number were sent via email immediately after the conversation ended.

8.4 Ethical considerations

Ethical approval was obtained from both the Salomons Centre for Applied Psychology and the research/ethics board of the hospital recruited from. However, consideration was given to the fact that participants being interviewed may have had their own previous experiences with eating difficulties. Additionally, some participants may have experienced significant changes to their eating habits and body image since beginning their work in eating disorder settings that they experienced as being negative. Therefore, time was set aside after the interview was completed to 'check in' with participants, and to discuss anything that may have come up that might have been experienced as personally difficult. Although this was not to be considered as therapy, it was decided that a space to think about any difficulties experienced and where to go with them would be beneficial for participants. Additionally, all participants were provided with a sheet containing contact details for various organisations, which may be useful if they were worried about the mood, eating habits or body image of either themselves or their colleagues (Appendix F).

8.5 Data analysis

Interviews were transcribed, and then analysed using the Strauss and Corbin (1998) version of grounded theory. This version was chosen, as it is thought to be more consistent with postpositivism and critical realism (Charmz, 2000), which was considered to be congruent with the epistemology of the researcher. Transcripts were initially coded using open coding, followed by selective coding. Codes were then considered in relation to each other, and

were arranged into categories and subcategories. Finally, a diagrammatical model was created which sought to explain how these concepts related to each other. Memos were kept throughout the coding process to track theory development (see Appendix G for examples).

8.6 Potential bias and use of bracketing

Strauss and Corbin (1998) highlight that interviews and data analysis do not occur in a vacuum; rather, the interview process and the subsequent data gathered are a complex interchange of participant experience and researcher interpretation, resulting in data that is co-created between the researcher and participant. Therefore, interviews and subsequent data analysis cannot be completely free of the preconceptions and experience that the researcher brings. However, to minimise bias, a number of bracketing techniques were used.

Although a traditional bracketing interview (Rolls & Relf, 2006) was not used, other methods have been suggested to bracket preconceived ideas which may interfere with the researcher's ability to engage with emerging data (Tufford & Newman, 2012). Therefore, the researcher used both memoing (Cutcliffe, 2003; Glaser, 1998) and reflexive journaling (Ahern, 1999) in an attempt to identify emerging beliefs and preconceptions which may have had a deleterious effect on the research if otherwise left unacknowledged. Examples of memoing and reflexive journaling can be found in Appendices G and H respectively.

8.7 Rigor and multiple coding

In an attempt to improve rigor, multiple coding was employed. Two independent peers drawn from the cohort of trainee clinical psychologists coded a transcript each. The assigned

codes were then discussed with the lead researcher. Generally, the codes assigned by the two independent peers were similar in nature to the codes assigned by the researcher, although with varying names. However, after discussing the concepts behind the codes, it became apparent that similar concepts were being highlighted.

9. RESULTS

During the interview and analysis process, three core categories were defined. These were: ‘past perceptions of self, body and eating’, ‘perceived changes’ and ‘participant reasoning of changes’, with ‘perceived changes’ being identified as the central category. Each of these categories consisted of a number of subcategories (see Table 2). Appendix I shows an example of a coded transcript, while Appendix J depicts the full coding table.

Figure 1 illustrates the hypothesised manner in which these concepts interplay to both create and maintain perceived changes to participant body image and eating. Historical perceptions of the self are proposed to develop within a social and familial context, forming a personalised background of beliefs around food, body image and exercise. Once working within an inpatient eating disorder setting, participants spoke about a complex interplay of the environment, the job almost seeming to promote chaotic eating, access to support and the impact of the patients themselves. These factors contributed to perceived changes to their food intake and body image, with aspects of their work spilling into their personal lives. These changes were then mediated by individual differences in management and the “personalised meaning” that participants assigned to changes. Once these changes had been noticed, ascribed a meaning and managed, participants gave further consideration to the work environment, access to support, availability of food due to their job and the impact of their patients, which had a further impact on the perceived changes. It is important to

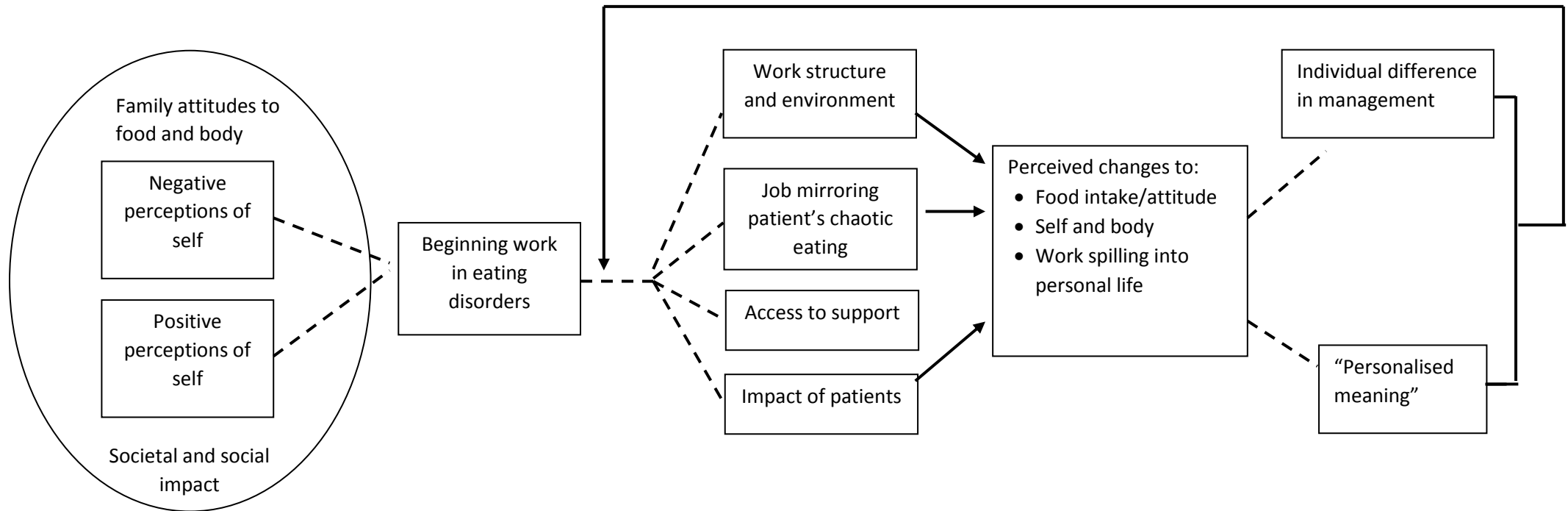
highlight that the changes noticed could be experienced as being positive, negative, or

Core category	Sub-category
Past perceptions of self, body and eating	Societal and social impact
	Family attitudes towards food and body image
	Positive perception of self
	Negative perception of self
Perceived changes	Changes to food intake and attitudes
	Changes to perception of self and body
	Work spilling into personal life
Reasoning of changes	Work structure and environment
	Job mirroring patient's chaotic eating
	Impact of patients
	Access to support
	Individual difference in management
	"Personalised meaning"

neutral.

Table 2: *Core categories and subcategories*

Figure 2: Diagram of hypothesised theory of perceived changes



Each of the three core categories and their subcategories will now be described, with quotes drawn from interview transcriptions to support and illustrate categorisation.

9.1 Core category 1: Past perceptions of self, body image and eating

9.1.1 Family attitudes towards food and body

Participants described a number of experiences from their childhood and adolescence around the ways in which family attitudes towards food shaped their perceptions of eating and their body. These experiences formed the bases of the attitudes and experiences with which participants entered the eating disorder environment, potentially shaping the reactions that were subsequently elicited. These attitudes varied widely, including the idea that food is necessary nourishment and should be consumed as and when needed as well as stories of unhealthy familial relationships with food. The cultural importance of food was also raised a number of times by participants, particularly those whose parents were from different cultures.

P03: *"...my family background, my culture...they encourage you to eat!"*

P 13: *"...and even just being away from home, it made me realise that my mother had quite an unhealthy obsession with weight"*

9.1.2 Societal and social impact

Naturally emerging from the data were descriptions of the impact that wider societal expectations and socially reinforced ideas had on participants. Many participants spoke about the socially ideal body types that they were encouraged to strive for, along with the impact that their peer group's perceptions had on their own desired body type. Some participants described feeling less pressurised to conform to a socially prescribed ideal,

largely due to the fact that their body already naturally met the desired type imposed by society. Many participants spoke about changes to their weight – either due to attempts at dieting or through a variety of other factors, such as changes to external circumstances – with the subsequent reaction from family and peers either positively or negatively reinforcing their new bodies. Gender was also raised as an idea here – although interestingly, it was only raised by the men who were interviewed.

P07: *“once I’d lost it (weight), and I went back to my second year at uni, and everyone was saying oh wow you look amazing kind of thing so there was pressure to keep it off”*

P13: *“the desired body type was almost androgynously thin, and seemed to be desired by the girls at school and the boys in the local school”*

9.1.3 Negative perception of self

Many participants spoke about a historically negative perception of themselves. This generally comprised participants feeling ‘overweight’, particularly in comparison to their peers. However, the extent to which these negative perceptions of the self impacted daily functioning of participants ranged from low self-esteem and a general feeling of difference, to diagnosed eating disorder histories.

P03: *“...I always felt kind of chunky, like compared to other friends at school...and when I was growing up I did try different diets...”*

P06: *“...by the time I was like 14 I actually did develop anorexia and had really bad body image”*

9.1.4 Positive perception of self

Although many participants highlighted negative ideas of themselves, historically positive ideas around body image also emerged from the data. Along with a general lack of consideration towards the body, some participants spoke about feeling as though their body met the socially desirable standards of shape and size – generally, that of being slim. Additionally, those who had experienced eating disorders previously generally spoke about a process of moving towards a more positive and accepting view of the self in which past difficulties were (at least partially) reconciled. Therefore the same participant would often speak about both positive and negative perceptions of themselves within the same interview.

P10: *"I've always eaten what I wanted and never really excessively put on weight, like the idea that I need to lose it isn't a big part of anything for me, so I am quite happy with how I am"*

P13: *"I realised that actually I had a normal body shape and really, it was probably on the smaller end of the spectrum...and for me it was the first time since childhood that I felt completely at ease with my body"*

9.2 Core category 2: Perceived changes

9.2.1 Changes to food intake and attitudes

Participants described a wide variety of changes to their food intake and attitudes towards food occurring since working in an inpatient eating disorder setting. Most commonly, participants felt as though they were increasingly aware of the calorie content of food. However, the subsequent impact that this had on participants' actual intake of food varied widely. Many participants noted that they felt an increased desire for health, and often modified their intake accordingly. However, comfort eating, weight gain and a shift to eating

more unhealthy food were also widely noted with varying explanations as to why participants felt this was occurring. Missing meals or restricting calories also emerged, however this was to a lesser extent.

P04: *"I shouldn't really wanna eat that but then I've found myself just eating it"*

P10: *"I'm more conscious of what's in food, in terms of calories or fat and things because before I never really thought about it at all"*

9.2.2 Changes to perception of self and body

In tandem with perceived changes to food intake and attitudes, an emerging category of changes to perception of the self and body image became apparent. Although a generally increased awareness of the body was dominant in the data, many participants spoke of additional changes that had become noticeable during the course of their work. Changes to the body types which were considered desirable appeared to be a particularly prominent concept – however, there was a range of variety, with some participants seeing thinness as less desirable, others wishing for a more 'curvaceous' figure, and old body image concerns resurfacing in which thinness was seen as the ideal to be aspired to.

P05: *"for me I don't think I'd want to be skinny anymore, I don't think I'd want to be skinny, but at the same time my ideal is being a bit curvier now"*

P13: *"I just find my focus shifting back onto my body in a way that I hadn't been troubled by since I was 18...I just find myself constantly feeling like one of the bigger people in that small, intense community of girls..."*

9.2.3 Work spilling into personal life

Participants not only spoke of changes to their body image and ideas of food, but also to their general individual behaviour. The described changes to behaviour all shared the common theme of aspects of work being adopted in participants' personal lives, from generally being more aware of the behaviour and body size of others to incorporating behaviours from work into their own repertoire.

P04: *"I remember outside of work around meal times, I was getting anxious, and it's so ridiculous, but I did"*

P05: *"...you know when they are eating you're meant to make sure most of the food is off the plate like scraping and stuff, like when I eat now, I don't leave excess food on the place cos you sit there and you think like oh actually you need to keep going"*

9.3 Core category 3: Reasoning for changes

Emerging from the data were distinct subcategories comprising the sense that participants made of the changes presented above. Interestingly, these seemed to fall into two broader categories – the impact of the broader work environment, which participants appeared to feel 'caused' the changes, and the differences in the ways that participants individually managed these processes.

9.3.1 Work structure and environment

A clear concept of the work structure and the nature of the job itself became apparent. Participants spoke about aspects of the job which, when done regularly enough, became part of their repertoire of behaviours – such as remaining hyper vigilant to others, or modelling specific behaviours. Participants also spoke about the information that was accrued during the course of their work which subsequently could not be ignored, such as

the accumulation of knowledge about the calorie content of food due to the weighing of food within the job role.

P10: *"...you have to get the kid's calories right because food is essentially their medicine, so there's no way of not knowing how many calories are in, like to a certain gram of yoghurt you know, so it just- it becomes a routine, you know you go in the morning, you do their breakfast, this child has this many calories which looks like this, the cooking you do is based on calories per portion so, you have to know it really really well"*

P11: *"I have set meal times where I have to eat in front of patients, and they're watching you to see how you eat and, part of our job is modelling good behaviours, you have to be aware of what you're doing in front of patients"*

9.3.2 Job mirroring patient's chaotic eating

Interestingly, numerous participants also spoke about the fact that the job almost appears to promote a chaotic or disordered pattern of eating. In particular, the nursing team (comprising the healthcare assistants and nurses) began their shift at between seven thirty and eight o'clock in the morning, and usually would not have their lunch break until around three or four o'clock in the afternoon. Many participants spoke about either eating more due to becoming extremely hungry, or missing later meals due to their late lunch, resulting in participants only eating once or twice in the course of the day.

P04: *"it's a 13 hour shift so you get your hour break but you won't get it 'till three or, about that time, like three or four, and I don't eat in the mornings, so I don't eat until....I don't usually eat until about four"*

P09: *"...most of the time when they get a lunch break it's at 3, 4, or 5, I've been working since 7am, so I've gone quite a few hours without stopping...but we, staff members who don't*

have eating disorders are forced into abnormal behaviours where they're going hours on end starving, and you can't eat anything"

9.3.3 Impact of patients

A complex interplay between the participants themselves and the patients that they were there to help support emerged from the data, in which patient-driven factors were thought to contribute to the overall sense of change that participants described. Participants often felt as though their bodies were being 'scanned' or 'checked' by their patients, with patients commonly engaging in body checking behaviours both during and after analysing participant bodies. Additionally, several patients had commented on staff bodies – either positively or negatively. This process of patients attending to participant bodies often brought the bodies of staff sharply into focus, with participants describing the general level of attention given to body weight, shape and size as contributing to their own awareness and consideration of their physicality. Additionally, the process of spending a significant amount of time amongst people of the level of thinness common in inpatient eating disorder setting was also described as having an impact on participants, with many describing a feeling of 'bigness' compared to small, underweight patients. Conversely, participants also spoke about their shock and disgust at extreme levels of thinness, which enabled participants to witness the impact of anorexia and extreme thinness. Furthermore, the amount of time spent with patients was considered to be a factor contributing to the level of change noticed by participants, with several of those who spent a significant proportion of their day (for example, healthcare assistants and nurses) describing how the process of simply being around patients for so long resulted in them feeling more susceptible to being negatively affected by their work.

P07: *"I wondered if it's helped, the fact that I'm not so on the floor, so I'm more removed, so I'm not on the front lines"*

P08: *"...there's nothing nice, there's nothing healthy, there's nothing good about it"*

P13: *"well it constantly feels as though patients are scanning your body, just sort of observing it or judging it, maybe in relation to their own, and I've had a couple of patients tell me that they are much bigger than me when, I mean clearly they're much smaller...and I find that, it's like a jarring reminder of my own body shape and size"*

9.3.4 Access to support

Availability of support emerged as a particularly common concept across participant interviews. Specifically, the extent to which participants felt supported by their peers, and the availability of spaces to discuss the emotional intensity of their jobs – for example, regular supervision – was described as having a large effect on the extent to which participants felt affected by changes to their eating and body image. Having space to consider the impact of the work on the self was repeatedly highlighted as helpful by those who received it, and needed by those who did not.

P06: *"so the top thing for me that's helped is supervision"*

P09: *"having a reflective practice space would be so helpful, even if I can't talk about my personal struggles, I could talk about my struggles on the ward in general"*

9.3.5 Individual difference in management

Participants repeatedly spoke about the role of pre-existing individual difference in the ways in which they made sense of and responded to potential changes while working in eating disorder settings. Historical ideas of body image and eating, cultural ideals, and external

activities were all described as being central to managing the intensity of working within eating disorders. Additionally, body shape and size was described as being potentially protective, with several of the participants with smaller body sizes wondering whether their experiences may differ if they were 'heavier'.

P05: *"in terms of my race growing up, my sister is quite curvaceous, nice figure and stuff...that's what a lot of black girls aspire to"*

P08: *"..having the knowledge like through doing psychology ... maybe that's helped as well, and just having a normal home environment where your eating was very relaxed"*

P10: *"...if I was more self conscious about it or if I was noticeably a lot more...heavier, I guess that would make it harder"*

9.3.6 "Personalised meaning"

This in-vivo subcategory was concerned with the meaning that participants constructed from their work, and encompassed the ideas of participants being 'on a journey'. During this process, participants described perceiving and responding to their own developing sense of self.

P05: *"...there are more important things to life than how you look, although sometimes people may not realise that...that's what this place has made me feel like"*

P06: *"...in the context of everyone's individual processes, I've been able to take away a little bit of meaning of my own from that"*

10. DISCUSSION

The aim of this study was to consider the ways in which staff body image and ideas of food may be affected by working in adolescent inpatient eating disorder environments, and to begin explaining why this may occur. The analysis described above attempted to describe and present the experiences of a range of staff working within adolescent inpatient eating disorder environments, to begin addressing this question. The model presented hypotheses that a complex interplay between pre-existing ideas of food and body image and the work environment itself contribute to perceived changes, which are then given meaning and managed by the individual. The way in which these changes are interpreted and managed then results in further interaction with the work environment and potentially further perceptions of change, resulting in a cyclical relationship.

10.1 Fit with previous research

The results of this study appeared reasonably consistent with the limited research previously undertaken within the area, indicating that the experiences discussed may not be confined to the two private hospitals used for recruitment. Experiences described by participants, such as feelings of 'bigness' compared to small patients (Walker & Lloyd, 2011), patients analysing or scanning staff bodies (Daly, 2012; Frankenburg, 1984; Warren et al., 2009), increased awareness of body size and shape (Daly, 2012; Derenne, 2006; Lowell & Meader, 2005), and changes to ideas of food and food intake (Shisslak, Gray & Crago, 1989; Warren et al., 2009) have all been noted in previous research. Additionally, the propensity to interpret changes to body image and perception of food as being either healthy (Shisslak et al., 1989; Warren et al., 2009) or unhealthy (Warren et al., 2009), regardless of previous eating pathology (Shisslak et al., 1989) indicates that there is no clearly defined process of

change dependent on previous eating history and body image. Although this piece of research attempted to identify and explain the changes that participants may experience independent of theoretical orientation, the processes described may be situated within established psychological theory. For example, the concept of countertransference within psychodynamic theory (Racker, 1968) describes the process in which therapists experience reactions in response to the transference of the patient. When left unanalysed, these countertransference reactions may be identified as being derived internally from within the therapist rather than being induced by the transference of the patient. Therefore, the changes experienced by staff working in eating disorders may be viewed as unnamed and unprocessed countertransference. However, this does not seem sufficient to explain the changes experienced by clinicians entirely, as a number of factors other than the patients themselves were described by participants (such as cultural ideals, the structure of the environment itself, historical ideas about food/diets, previous eating disorder pathology, access to support, and so on.). An alternative framework which may encompass some of these other factors is that of Narrative Therapy. Narrative theory postulates that people give meaning to the events experiences throughout their lives, constructing a dominant story, or 'narrative' (Morgan, 2000). This seemingly fits with the subcategory of "personalised meaning", in which participants derive individualised meaning from their experiences within eating disorders. Additionally, the way in which participants construct their identities prior to working within eating disorder settings – for example, as being 'slim', 'attractive' or 'not needing to diet' – may impact the aspects of experience which they choose to attend to and add to their repertoire of experiences which contribute to the dominant narrative of themselves. Meanwhile, more feminist theories may describe the process by which women are designated as being 'powerless' within society. Therefore, women are socialised to

believe that their value rests on their ability to attract the more powerful, dominant men who are able to provide financial security. This process of reducing a woman to her ability to attract a mate results in a woman's worth becoming tied up with her physical appearance, resulting in competition between women and feelings of worthlessness when women are unable to meet the ideals imposed on them by society (Bloom et al., 1994; Bloom, 2002; Orbach, 2006). As such, when women enter an environment such as that of an inpatient eating disorder unit in which they are surrounded by focus on weight, body image and eating habits, they may begin to question their own value and ability to meet society's expectations. Additionally, their prior socialisation regarding the desirability of thinness and the location of their value in their physical attractiveness may mean that they are pulled into a process of competition with other women – namely, their patients. Regardless of the theoretical underpinning used in an attempt to understand the processes occurring, what remains clear is that there does indeed appear to be a process in which staff are impacted by their work, whether that be interpreted as being positive or negative.

10.2 Limitations

Although attempts were made to increase the credibility, transferability and dependability of the study, there were still a number of limitations.

Firstly, organisational difficulties, limited resources and time constraints resulted in a reasonably small number of participants. Therefore, many of the concepts did not reach saturation, but rather theoretical sufficiency was used instead. Therefore, it is entirely possible that a larger sample size may have resulted in further concepts emerging, which may have subsequently affected the model hypothesised to explain the process of change to body image and eating habits described by staff. Further research using a larger sample

would be needed to assess whether the same concepts continue to emerge from the data, and whether there may be further categories or subcategories which were not uncovered during this project.

Additionally, although the project was open to all members of the multidisciplinary team, the vast majority of those taking part were either healthcare assistants or assistant psychologists. It is entirely possible that the lack of formal clinical qualifications, lower degree of supervision or the higher level of contact time with the patients inherent within these job roles in particular may have resulted in these staff members noticing the highest degree of change, resulting in them feeling a stronger desire to participate; however it is also entirely possible that there are other factors which may have affected the willingness of other staff groups to participate in this study. Therefore, the hypothesised model constructed may not be transferrable to others working within eating disorders outside of the job roles stated. Additionally, recruitment was based across two private inpatient adolescent inpatient hospitals. Results therefore may not be transferrable to those working in NHS settings, outpatient/community settings, or those working with adults. Further research would therefore be required to assess the transferability and replicability of the categories and hypothesised model.

Finally, although attempts were made to increase rigor and limit potential researcher bias, the epistemological standpoint of the researcher remains that the experience of others cannot be independently and impartially measured. The co-construction of interview data takes place through a combination of questions selected by the researcher, participants' expression of experience (coupled with the experiences that they choose not to share) and subsequent interpretation of these shared experiences by the researcher. Therefore, this

process cannot be completely independent of the researcher's influence despite attempts to identify and minimise this where possible.

10.3 Clinical implications

The data from this study suggests that many of the changes experienced by staff are experienced as healthy or positive. For staff themselves, this may have a positive impact on their wider quality of life and view of self; however this may also have a positive impact on their ability to interact with patients – particularly with regards to modelling healthy attitudes towards food and body image (although further research may be needed to explore this). However, the implications regarding those who experience negative changes are far more significant.

Although previous research has highlighted the role of supervision in preventing exhaustion and burnout in those working within mental health settings across multiple different professions (Edwards et al., 2006; Spence, Wilson, Kavanagh, Strong & Worrall, 2001), participants within this study frequently described a lack of supervision, which was often discussed in relation to the more difficult processes described. If availability of support does have an impact on the changes staff members experience in relation to their body image and eating habits, then the importance of providing regular, frequent and adequate supervision for staff cannot be understated.

Additionally, the structure of the environment itself emerged as a subcategory within the category of perceived change, indicating that there may be something in the structure of inpatient adolescent eating disorder environments which causes or contributes to the changes described. While some of these organisational processes may be more obviously difficult (for example, staff members being required to work for around eight or nine hours

before getting a break to eat or drink water), it appears as though other processes may also be affecting the staff – for example, the requirement for staff to calculate food calories for patients. Organisations may therefore wish to reconsider the duties which are allocated to staff, or implement further support networks in an attempt to allow staff to have a space to discuss how the organisational structure in itself may affect them.

10.4 Further research

As previously mentioned, further research is required to assess whether the model proposed is transferrable to other staff groups and settings, and whether it is replicable. However, as research into the ways in which staff may be affected by their work is still a reasonably new area, this project also raises a number of other questions.

One such area for further exploration is whether implementation of supervision along with other spaces for staff to discuss their experiences during the working day may affect the level of change experienced by staff, or the meaning made of these experiences.

Additionally, spaces to explore previous body image concerns – particularly those which may be unresolved – and how these may be affected by the weight and food focused environment of an inpatient eating disorder environment would also be an interesting consideration for further research. Furthermore, it may be interesting to use quantitative analysis in an attempt to identify whether there are particular factors which may explain the difference in whether positive or negative changes are experienced, and the extent to which these affect the individual.

Finally, one of the considerations which struck the researcher was the fact that many of those interviewed identified themselves as having previous eating disorder histories. While some of these participants appeared to find the nature of the environment ‘triggering’,

many others spoke of moving towards a place of bodily acceptance and increased health during the course of their work. Indeed, many of the participants spoke about their shock at not being more affected by their work. As such, future research may wish to explore the way that those with previous histories of eating disorders manage these environments, and the way in which they construct their new identities as 'staff' rather than 'patient'.

11. CONCLUSION

While there is some evidence to suggest that those working in eating disorders do experience changes to their body image and eating habits, whether these are experienced as positive or negative and the extent to which they affect participants' lives is varied. While some participants felt as though they moved towards more disordered eating or problematic body image, others reported feeling as though they were now engaging in more healthy eating, with a more positive view of the self. A model of changes to body image and eating habits was presented, in which a complex interplay of pre-existing attitudes towards the body and eating, the inpatient eating disorder environment itself, access to support and interactions with patients contributed to the development and maintenance of changes to body image and eating habits. The meaning that participants ascribed to these changes and their individual attempts at management then had a further impact on the extent to which participants felt changes were helpful or harmful. Generally, the results obtained and the hypothesised model of change fit with previously conducted research into the area, and can be situated within wider psychological theoretical underpinnings. However, limitations within the methodology along with a small sample size mean that further research into the area is needed.

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Section C: Appendix of Supporting Material

Appendix A: quality criteria

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Appendix B: Participant information sheet

Information about the research**Body image and eating habits of eating disorder clinicians**

Hello. My name is Lisa Keenan and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.

(Part 1 tells you the purpose of this study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the study).

What is the purpose of the study?

While lots of research has been targeted at people with eating disorders, recently the focus has shifted onto staff working with eating disorders and the effect that this may have. I am interested in exploring the body image and eating habits of people working in inpatient eating disorder hospitals. As part of this, I am looking at peoples past and current body image and eating habits, whether staff feel as though this may have changed or been affected since working in an inpatient eating disorder unit and how staff view these changes.

Why have I been invited?

All staff who work in eating disorder settings are being invited to take part in this piece of research. I would like to speak to a wide variety of staff, including healthcare assistants, nurses, and therapists.

Do I have to take part?

Taking part in this study is completely voluntary. If you agree to take part, I will ask you to sign a consent form. You can withdraw at any time, without giving a reason. This includes during the interview and after the interview has taken place.

What will happen?

We will meet to have a discussion about your body image and your eating habits. We will meet once for roughly an hour, however I may ask you to leave an email address just in case I need to get in touch to clarify anything that we have talked about. I will be recording these conversations using a Dictaphone since we will be talking about quite a lot of different things, but these recordings will be transferred to an encrypted USB stick and will only be listened to by me.

Expenses and payments

Where possible, I will try to organise to meet with you during one of your normal shifts to make it as easy for you as possible to attend. However, as work in the hospital can be unpredictable, this may not be possible for a number of reasons. If it is not possible to meet with you during one of your regular shifts, I may ask you to come in on one of your days off. If this is the case, I will reimburse travel expenses up to £10.

What are the possible disadvantages and risks of taking part

We may be discussing some things that could be potentially quite difficult – for example, if you have a past history of eating disordered behaviour. You will be provided with a full debrief at the end of the interview, and everyone taking part in the research will be given a sheet with contact details that might be useful if you are ever worried about your eating habits or mood

What are the possible benefits of taking part?

In return for taking part in the study, you will be entered into a prize draw to win one of four £10 vouchers of your choice.

Working with eating disorders can be hard work, and we are only just beginning to understand the effect that this can have on staff. By looking at these effects more closely, we can begin to make sure that staff are getting the correct support. I cannot promise that the results will benefit you directly; however I will be sharing the results with the hospital so that hopefully the kind of support that staff are able to access can be refined if necessary.

We are also becoming more aware that recovering from an eating disorder does not happen in isolation, and it is only possible in the context of a good therapeutic relationship. But building this relationship can be incredibly difficult for staff, particularly where staff are not receiving adequate support to manage some of the issues that may come up. It is possible that understanding some of the difficulties experienced by staff may also help therapeutic relationships, and therefore help patients to recover.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. Further details are included in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2 of the information sheet**What will happen if I don't want to carry on with the study?**

You will be free to withdraw at any point in the study without giving a reason. If you wish to stop the interview, you simply need to say that you do not wish to continue. If after the interview you decide that you would like to withdraw your information, please contact me using the details provided and I will erase the recording of your interview and I will not use it during the study.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions. You can contact me by leaving a message for me on a 24-hour voicemail phone line at **01892 507673**. Please say that the message is for Lisa Keenan and leave a contact number so that I can get back to you. Alternatively you can email me at **L.Keenan192@canterbury.ac.uk**. If you remain unhappy, you are entitled to make a formal complaint to: **[insert details eg NHS Complaints Procedure or Private Institutional arrangements]**. Details can be obtained from **[insert details]**

Will my taking part in this study be kept confidential?

Anything that we discuss during the interview will be kept confidential, and **will not** be discussed with anyone. This includes disclosures of past experiences of eating disorders and so on. The only exception to this is if you were to tell me anything that made me worried you may be high risk to yourself or others – for example, if you disclosed that you were currently at high risk of committing suicide, then I may need to discuss this with another team member to ensure that we are keeping you safe.

The interviews will be recorded using a Dictaphone, and all recordings will be transferred to an encrypted password protected USB stick before leaving the hospital grounds. No-one else will listen directly to these recordings, and any quotes that are used in my thesis will be completely anonymised so that they cannot be traced back to you.

The recordings will be retained for approximately a year due to the process of writing up my thesis and submitting it to the university. After this it will be destroyed.

What will happen to the results of the research study?

Results of this research will be shared with the hospital, and will be written up for submission to Canterbury Christ Church University for my doctorate. Quotes may be used in the write-up, however where this occurs these quotes will be completely anonymised and will not be traceable to you or anyone else. The results of the study may additionally be submitted to an academic journal, where these same conditions will apply. You will not be identified in any report or publication.

If you would like to have a copy of the results, you can email me at l.keenan192@canterbury.ac.uk and I will email you a copy of the study once it is complete.

Who is organising and funding the research?

This research is being organised through (retracted) and is being overseen by Canterbury Christ Church University (CCCU). CCCU is funding the research.

Who has reviewed the study?

All research is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Salomons Research Ethics Committee.

If you would like to speak to me and find out more about the study or have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at 01892 507673. Please say that the message is for Lisa Keenan and leave a contact number so that I can get back to you.

Appendix C: Consent form

CONSENT FORM

Title of Project: Body image and eating habits of eating disorder clinicians

Name of Researcher: Lisa Keenan

Please initial box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.

☐

4. I agree to this interview being recorded – audio only

☐

5. I agree that anonymous quotes from my interview may be used in published reports of the study findings [if applicable]

☐

6. I agree to take part in the above study.

☐

Name of Participant _____ Date _____

Signature _____

Name of Person taking consent _____ Date _____

Signature _____

Appendix D – Demographic collection sheet

Demographic information

As part of my research, I am collecting very brief information about the people that I am interviewing. This is just to help me understand the people that I am interviewing and their replies a bit better, and to make sure that I am speaking to people from a range of different backgrounds. This information will not be used to identify you in any way.

Age:

- | | | | |
|----------------------------------|----------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> 16 – 18 | <input type="checkbox"/> 18 – 19 | <input type="checkbox"/> 20 – 24 | <input type="checkbox"/> 25 – 29 |
| <input type="checkbox"/> 30 – 34 | <input type="checkbox"/> 35 – 39 | <input type="checkbox"/> 40 – 44 | <input type="checkbox"/> 45 – 49 |
| <input type="checkbox"/> 50 – 54 | <input type="checkbox"/> 55 – 59 | <input type="checkbox"/> 60 – 64 | <input type="checkbox"/> 65+ |

Gender:

- | | | |
|-------------------------------|---------------------------------|---|
| <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> Do not wish to say |
|-------------------------------|---------------------------------|---|

Ethnicity:

White:

- ☐ English/Northern Irish/Welsh/Scottish
- ☐ Irish
- ☐ Gypsy/Traveller
- ☐ Other

Black:

- ☐ African
- ☐ Caribbean
- ☐ Other

Mixed:

- ☐ White & Black African
- ☐ White & Black Caribbean
- ☐ White & Asian
- ☐ Other

Asian:

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Other

Job title:

How long have you work in this hospital:

- ☐ 0 – 1 year ☐ 1 – 2 years ☐ 2 – 5 years
☐ 5 – 9 years ☐ 10 years+

How long have you worked in eating disorders overall (including past jobs):

- ☐ 0 – 1 year ☐ 1 – 2 years ☐ 2 – 5 years
☐ 5 – 9 years ☐ 10 years+

Do you have a history of eating difficulties?

If yes, please give a brief outline

Appendix E – Interview Schedule

Introduction:

Personal introduction
Confidentiality
Brief explanation of study
Questions
Consent sheets

Past experience:

Body image when young (childhood)
Eating habits when young
Body image as a teenager
Eating habits as a teenager
Past experience of eating disorders?

Adulthood experiences:

Adult body image
Adult eating habits
If these have changed? How were changes from youth/teenage years/adulthood reconciled?

Experiences since working in inpatient eating disorders:

Body image since working in eating disorders
Eating habits since working in eating disorders
Any changes? Sense made of these?
Patient reactions to staff body type
Patient reactions to staff eating habits
Participant reactions to staff body type/eating
Any other positive or negative experiences since working in eating disorders

Therapeutic relationship

Experience of building relationships with patients in general
Effect that patient reactions may have had on ability to build therapeutic relationship (if relevant?)
Exploration of therapeutic relationship in the context of own body image
Exploration of therapeutic relationship in context of own eating habits

Protective/risk factors

Conclusion

Full debrief about research project
Provide contact telephone numbers sheet
Discuss any concerns about safety with interviewee (if relevant)
Questions

Appendix F – Useful contact numbers

Useful Contact Numbers

If you are or ever do become worried about your eating habits, in the first instance you should contact your GP. However, the following might be useful alternative sources of support:

b-eat

Charity supporting anyone affected by eating disorders or difficulties with food, weight and shape.

Website: <http://www.b-eat.co.uk/>
 Helpline (adult – 18+): 0845 634 1414 or email help@b-eat.co.uk
 Helpline (youth – under 25): 0845 634 7650 or email fyp@b-eat.co.uk

Eating Disorder Support UK

Organisation providing support for anyone affected by an eating problem, including anorexia nervosa, bulimia and binge-eating disorder. Also provides support for those caring for people with eating disorders.

Website: <http://www.eatingdisorderssupport.co.uk>
 Helpline: 01494 793223
 Email support: support@eatingdisorderssupport.co.uk

Caraline

Provides a helpline, counselling and support groups for those living with eating disorders

Website: <http://www.caraline.com>
 Helpline: 01582 457474
 Email: caralineed@aol.com

Men Get Eating Disorders Too

Online support and information specifically for men with eating disorders, or those who know a male with an eating disorder.

Website: <http://MenGetEDsToo.co.uk>

Overeaters Anonymous

Organisation offering support for people who experience compulsive over eating.

Website: <http://www.oagb.org.uk>
 Telephone: 07000 84985
 Email: general@oagb.org.uk

Samaritans

Confidential support for people feeling distressed

Website: <http://www.samaritans.org>
 Helpline: 08457 90 90 90
 Email support: jo@samaritans.org

SupportLine

Confidential telephone helpline offering support to anyone on any issue

Website: <http://www.supportline.org.uk>
 Helpline: 01708 765200
 Email: info@supportline.org.uk

Appendix G – Examples of memos

Memo 1

Participant talking about ‘picking up behaviours’. To me this implies unconsciously mirroring behaviours. I wonder whether participant’s belief is that you ‘accidentally’ replicate behaviours? Is there a cognitive element? Seems to imply lack of cognition/will/desire. Possibly separation of codes relating to consciously choosing to replicate behaviours versus accidentally replicating without will?

Memo 2

Notion of ‘committing’ to exercise strikes me – is exercise something to be ‘committed’ to rather than sporadically done? Such as part of social life? Commitment in monogamous relationships – select one, and only one, without cheating. Would it be ‘cheating’ to miss a day of exercise? Do you need to select one exercise and stick to that without cheating? Is food/diet viewed similarly?

Memo 3

Participant using the word ‘bruising’ strikes me as interesting. Makes me think of a physical wound or mark – has participant felt work to be physically damaging? When you get a bruise, it’s painful and gets visibly worse (turning black) before it gets better. But, bruises don’t break the skin or lead to scars, which makes me think the discomfort/pain of work is temporary, although painful and obvious? Should this be separate code – seems to capture more than just work being difficult/stressful. Must remain mindful of this with other transcripts.

Memo 4

Use of phrases ‘pulled down’ and ‘sucked under’ make me think of a tide you’re fighting against, almost like an undercurrent which may catch you off guard if not considered properly. Is the influence of work an ‘undercurrent’ which ‘pulls people down’ before they are aware? Also strikes me as negative. Instantly I think of the sea and drowning – it does not conjure positive imagery for me. Is this my own bias?

Memo 5

Idea that work has resulted in scrutiny of own health. But what is health? Were behaviours unhealthy before? Or has idea about what constitutes healthy changed? Seems as though participant experiences this positively – so perhaps work has contributed to improvements in quality of life? Perhaps unique to eating disorders. I am considering alternative jobs such as banking – would work result in personal insights into own health, resulting in healthy changes? I think of LD environments – do staff appreciate own comparative opportunities and independence? Consideration of own health seems important to ED work – perhaps seeing someone so close to death brings insights which are not obtained in other mental health settings where physical considerations are not as strong?

Appendix H – Extracts from research diary

05 March 2016

Spoke to (external supervisor) again today. She has informed me that they will essentially be recruiting an entire new staff team for the new hospital. Most of the qualified mental health professionals will be going over – however, the new hospital is going to be in (retracted), which has no transport links meaning all staff have to drive to be able to get there. It's also about 20 miles away from the current site and technically outside of London, so lots of people have already said that they will not be able to go when the new hospital opens. This has made me really worried – initially I was hoping to speak to people who had worked in Eating Disorders for at least a year, but that's just not going to be possible if they're recruiting a whole new staff team. I'm going to drop it to six months, which I said I would on my ethics form if there were issues, but this still means I won't be able to interview new starters until October at the earliest. I'm going to hope that a few of the staff members who are moving from the old hospital will be interested in my project, and then fingers crossed I can make up the numbers in November/December if needed! I'm definitely feeling slightly more anxious at this point but it all still seems so far off that I'm trying to remain hopeful.

22 April 2016

I've been talking about the move with (external supervisor). Apparently it has been more difficult than initially thought due to issues with recruitment and getting everything transferred over, so I'm going to have to wait a bit longer to begin recruiting, as everything at the new hospital is still very chaotic. Although I'm frustrated, I can't help but think that this constant state of flux is so common in healthcare settings at the moment. It's very strange to realise that this isn't limited to the NHS, and actually private sector services don't seem to be immune to the chaos.

30 September 2016

I'm very, very annoyed. The ward manager gave me the wrong date, meaning I missed the business meeting. The next one will be held on a Monday, when I'll be on placement in Margate, and the December one is cancelled due to Christmas. I cannot leave it until January to begin recruitment, but my supervisor seems to want me to just attend the meeting. I must email her to really emphasise that leaving it until then will make it far too difficult. I'm also going to have to use my contacts at (alternative private hospital), to see if I can recruit from there as I'm getting very panicky about this all now.

9 December 2016

I had a bumper day of interviews today (four people!) which have left me absolutely exhausted. However, I was really struck by how all of the participants wanted to ask me questions about being a trainee and getting on the doctorate after the interviews were finished. I'm more than happy to help and give advice, however I'm a little bit worried that people are only taking part in my research to have one-to-one access to a trainee. Will this skew my results? Will people who would not have been interested otherwise now wish to take part? I have to keep an eye on this.

12 January 2017

I also just finished an interview which threw up a lot for me. The participant was obviously very angry at her employer and the impact that working in eating disorders was having on her personally. I found myself really identifying with that feeling of being unsupported, due to my own experiences of working in eating disorders pre-training. I had forgotten how frustrated I had been as a healthcare assistant, but it all came back to me hearing her talk. During and immediately after the interview, I could feel my brain whirring – my mind went straight to how the lack of support available coupled with the emotional difficulties of the setting itself were causing the difficulties that staff experienced. However, once the interview was finished and I was driving home, I realised that I had become very drawn to over emphasising the negative experiences that the participant described, which meant that I had begun to construct a theory centred around them despite the fact that I have conducted a couple of interviews which do not fit with this. Although the negative experiences of this participant dominated her interview in particular, there have been many who have not had such intensely negative experiences. I have tried to make sure that I am giving space to positive, negative and neutral interpretations of experiences, but today just reminded me that sometimes our own experiences cannot be put aside entirely. I think the Importance of remaining aware of my own experiences and biases was really hammered home for me today.

17 January 2017

Today I'm feeling frustrated, hopeless, angry, anxious, and a million other things all at once. The secondary recruitment site I had been depending on have withdrawn from my experiment after they realised the extent of the primary recruitment site's involvement, as the hospitals have a longstanding rivalry. This comes after the nursing team at my primary recruitment site decided a couple of weeks ago that they can no longer allow healthcare assistants and nurses time away from the wards to take part in my research during their normal shift. I'm now absolutely terrified that I'm not going to be able to recruit enough people in time for the submission, as the hospital move had already pushed me pretty close to the wire. This project is just turning into one problem after another. I'm trying to think creatively about how to get around this – I'm wondering whether telephone interviews may be a good idea, as it means that healthcare assistants and nurses can take part in the comfort of their own home rather than having to come in before or stay after a 13.5 hour shift. I'm also wondering whether I should remove my minimum length of employment full stop to maximise recruitment. I will discuss with (external supervisor) and possibly consider requesting a change to my ethics. On the plus side, I've completed quite a few interviews, most of the have been transcribed, my Part A is almost finished, and I have also written the parts of my Part B which I am able to (e.g. introduction).

16 March 2017

The development of my model has been harder than I thought. I initially only wanted to line-by-line code two of my transcripts, but I ended up doing half of them. After I coded everything, I wrote out all of my codes and developed focused codes, as I had named the same concept slight variations of the same thing. Then I cut out my focused codes and started to arrange them into very broad categories, which I wrote on post-it notes. Then I arranged the focused codes for each category into subcategories. I also wrote these on post-it notes which I arranged under the broader categories. I found that some of the focused codes fit into more than one category, while some didn't seem to obviously fit into any. Constructing a model which fit the data was difficult, in that I had an idea of

how the categories and subcategories fit together, however putting this across in a way that made sense and captures what I wanted to say visually took me a while.

Appendix I

This has been removed for electronic submission

Appendix J - Full coding table

Core category	Sub-category	Codes
Past perceptions of self, body and eating	Societal and social impact	Socially driven desire for thinness Gender and social expectations for body and eating Negative reinforcement to stay slimmer Weight loss positively reinforced Weight loss eliciting negative reactions from others
	Family attitudes towards food and body image	Family encouraging variety of food in moderation Meals as family time when growing up Familial unhealthy relationships with food Cultural importance of food
	Positive perception of self	Lack of concern about body Increasing satisfaction with body Body fit desirably shape and size Exercising for enjoyment
	Negative perception of self	History of dieting History of restriction and over-exercising Past negative perception of body History of eating disorder Pervasiveness of difficulties with body image History of feeling overweight
Perceived changes	Changes to food intake and attitudes	Gaining perspective into own health Desire to be healthy Increased awareness of calories Eating more since working in eating disorders Weight gain since beginning work Job structure/routine enforcing more regular eating Emotions impacting food intake Shift to eating more unhealthy food
	Changes to perception of self and body	Thinness less desirable No changes to body image

		<p>Increased awareness of body</p> <p>Old body image concerns resurfacing</p> <p>Desensitization to thinness</p> <p>Negative perceptions of self</p> <p>Desire for more curvaceous body since beginning work</p> <p>Changing ideas of ideal body type</p> <p>Feeling big compared to small patients</p> <p>Envy towards patients</p>
	Work spilling into personal life	<p>Focus on food and weight 'taking over'</p> <p>Awareness of risks of eating disorders</p> <p>Associating meal times and anxiety</p> <p>Rules at work being adopted at home</p> <p>Incorporating modelled behaviour into own repertoire</p> <p>More alert to thinness in others outside of work</p>
Participant reasoning of changes	Work structure and environment	<p>Having to model positive behaviours</p> <p>Difficult nature of job</p> <p>Immersion in food and weight focused environment</p> <p>Knowledge of food and calories necessary for job</p> <p>Shift work impacting time for self</p> <p>Overworked/lack of time</p> <p>Work environment emulating previous experience</p> <p>Need to be hyper vigilant in job</p>
	Job mirroring patient's chaotic eating	<p>Weighing food part of job role</p> <p>Long periods without food due to job structure</p> <p>Job reinforcing disordered eating</p>
	Impact of patients	<p>Feeling big amongst small patients</p> <p>Shock at extreme thinness</p> <p>Patients commenting on staff bodies</p> <p>Appreciating comparative lack of difficulties</p> <p>Amount of direct contact with patients mediating impact</p> <p>Patient focus on bodies bringing participant body into focus</p> <p>View of patients as missing out due to illness</p> <p>Witnessing impact of anorexia</p>

	Access to support	Positive self talk Support from peers importance of supervision Place to voice experience and difficulties needed Lack of space to consider impact of work
	Individual difference in management	Cultural ideas of curvaceous bodies as ideal protective Role of knowledge/experience Personal interest Balanced relationship with food protective Role of gender Social acceptability of weight and body size/shape Personal resilience Impact of existing body image Interests and activities outside of work protective Separation of 'inside' and 'outside' worlds
	"Personalised meaning"	Developing self-awareness Developing realisation that looks are insignificant Gaining perspective Unavoidable application of knowledge to self Changes perceived positively Witnessing suffering of others bringing insight to self Consideration of own body in relation to patients Appreciation of own health Fear of becoming like patients Thinness becoming pointless pursuit "Self-analysis" Unconscious becoming conscious

Appendix K – Ethical Approval Letter

This has been removed for electronic submission

Appendix L – Research summary for CCCU ethics board

To Whom It May Concern,

RE: “Food for thought and thoughts of food”: A grounded theory analysis of the impact of inpatient eating disorder environments on staff body image and eating habits

I am writing to confirm that the above named study is now complete. I am including a summary of the research for your records.

Please do not hesitate to contact me if you have any further questions.

Yours sincerely,

Lisa Keenan
Trainee Clinical Psychologist

Summary of Research

Background

Although the impact that therapeutic work may have on therapists is not a new area of research in general, research specifically looking at those working in eating disorder environments remains a relatively under researched area. Generally, there are a limited number of studies into this area, with many of the existing studies using study design which rely on homogenous groups, which utilise surveys, or which employ single case designs. Additionally, all previous studies have focused exclusively on qualified individuals, with a general bias towards therapists and psychologists.

Aims

This study sought to use a grounded theory design to begin constructing an understanding of whether changes to body image and eating habits occur, why these may occur, and how members of staff make sense of these changes.

Method

Thirteen members of staff were recruited from two private inpatient adolescent eating disorder hospitals, of which eleven were female. Staff were recruited from a range of different professionals, however there was a general lack of response from ‘qualified’ clinicians, such as psychiatrists and psychologists. Interviews were analysed using the Stauss and Corbin (1998) version of grounded theory. Initially open codes were generated, followed by the development of eighty-nine focused codes. These were then arranged into broad categories, with sub-categories subsequently developed. A theoretical model hypothesising the interplay of these categories was then developed.

Results

Three core categories were developed, which were ‘past perceptions of self, body and eating’, ‘perceived changes’ and ‘participant reasoning for changes’. A model was developed which postulates that historical perceptions of the self develop within a social and familial context, forming a personalised background of beliefs around food, body image and exercise. Once working within an inpatient eating disorder setting, participants spoke about a complex interplay of the environment, the job almost seeming to promote chaotic eating, access to support and the impact of the patients themselves. These factors contributed to perceived changes to their food intake and body image, with aspects of their work spilling into their personal lives. These

changes were then mediated by individual differences in management and the “personalised meaning” that participants assigned to changes. Once these changes had been noticed, ascribed a meaning and managed, participants gave further consideration to the work environment, access to support, availability of food due to their job and the impact of their patients, which had a further impact on the perceived changes. It is important to highlight that the changes noticed could be experienced as being positive, negative, or neutral.

Implications

Changes which are experienced as positive may have a positive impact on the wider quality of life and view of self of staff, along with their ability to interact with patients – particularly with regards to modelling healthy attitudes towards food and body image. However, there was also a general consensus that a space to discuss difficult experiences was needed, with many participants discussing a lack of supervision as particularly problematic. Additionally, the structure of the environment itself and how this may contribute to or maintain perceived changes was repeatedly discussed by participants. This research may therefore have implications for the necessity of regular supervision. However, further research is needed to assess whether the model proposed is transferrable to other staff groups and settings, and whether it is replicable.

Appendix M – Summary of results for participants

Dear (participant name).

RE: “Food for thought and thoughts of food”: A grounded theory analysis of the impact of inpatient eating disorder environments on staff body image and eating habits

I would like to thank you for taking part in my research project. During the interview process, many participants expressed interest in hearing about the results. Therefore, I am attaching a brief summary of my research and the findings.

I would like to thank you for taking the time to discuss your experiences of working at (hospital name) and how they may have had an impact on your body image and eating habits, whether positively or negatively. It has helped to contribute towards a previously under researched area around the impact that work may have on staff members. If you would like a more extensive account of the research and the findings, or if you have any questions about the research itself, then please do not hesitate to contact me.

Thank you once again for your time.

Lisa Keenan
Trainee Clinical Psychologist

Summary of research

Background

In general, there has been a lack of research into how staff may be affected by their work in eating disorders. Research that has been done has tended to focus on therapists, and has excluded members of staff without a formal qualification such as healthcare assistants, assistant psychologists, occupational therapy assistants, and so on. Additionally, existing research has tended to use surveys, which mean that the range and depth of different experiences may have been missed.

What we hoped to find out

This research project attempted to hear more about the experiences of staff working in eating disorders and how these experiences may have resulted in changes to eating habits and body image, whether positive or negative.

What we did

Thirteen people took part, of which eleven were female. Staff from a range of job roles took part; however, the majority of participants were therapeutic care workers/healthcare assistants or assistant psychologists. Everyone was interviewed about their previous experiences of eating and body image, whether they had noticed any changes since working in eating disorders, and how they made sense of these changes. Interviews were transcribed and analysed using Grounded Theory, which aims to build a theory of why something may be occurring in an area which has previously been under researched.

What we found

We found out that there is a complicated interaction between pre-existing ideas about food and body image and experiences since working in eating disorder settings. Everyone spoke about their own personalised background of beliefs about food, body image and exercise, which seemed to be affected by family and social ideas. Once working in eating disorders, the environment itself, access to support and the impact of the patients themselves all contributed towards changes in eating habits and body image, with some parts of work ‘spilling over’ into peoples’ personal lives. People then managed these changes

in different ways and gave the experiences their own “personalised meanings”. This then fed back into how people managed the work environment, availability of support and the impact of the patients. It is really important to note that these changes could be experienced as positive changes (such as trying to be healthier), negative (such as people feeling more unhappy with their body) or neutral (such as people being more aware of their body but not caring!).

What this might mean

Although more research is needed to check whether this research applies to other hospitals and settings, it seems to show that people are affected by their work, whether that be better or worse. Some people may be happier and find it easier to engage with their patients, whereas other people may find the environment too difficult to cope with. However, having space to discuss these experiences seems to be particularly important. Also, it might be helpful to think a bit more about the environment itself and the affect that this has. For example, loads of people spoke about the effect that having to weigh food had on them.

Thank you for your participation!

Lisa Keenan
Trainee Clinical Psychologist

Appendix N: Journal submission guidelines

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium. If there is a related paper under consideration at another journal, a copy of that paper should be submitted with the primary manuscript as supporting information.

Authors should follow the guidelines carefully; failure to do so will delay the processing of the manuscript. **Once the submission has been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at mc.manuscriptcentral.com/ijed.** Authors unfamiliar with ScholarOne can find details on how to use the system here: www.wileyauthors.com/scholarone.

The submission system will prompt the author to use an ORCID iD (a unique author identifier) to help distinguish their work from that of other researchers. Details can be found [elsewhere](#) in these guidelines.

For help with submissions, authors should contact the Editorial Office: ijed@wiley.com. When necessary, the Editorial Office staff may refer questions to the Editor-in-Chief or Associate Editors.

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2. AIMS AND SCOPE

The International Journal of Eating Disorders—A leading peer-reviewed journal in the fields of psychology, psychiatry, public health, and nutrition & dietetics.

Mission: With a mission to advance the scientific knowledge needed for understanding, treating, and preventing eating disorders, the International Journal of Eating Disorders publishes rigorously evaluated, high-quality contributions to an international readership of health professionals, clinicians, and scientists. The journal also draws the interest of patient groups and advocates focused on eating disorders, and many of the articles draw attention from mainstream media outlets.

Scope: Articles featured in the journal describe state-of-the-art scientific research on theory, methodology, etiology, clinical practice, and policy related to eating disorders, as well as contributions that facilitate scholarly critique and discussion of science and practice in the field. Theoretical and empirical work on obesity or healthy eating falls within the journal's scope inasmuch as it facilitates the advancement of efforts to describe and understand, prevent, or treat eating disorders. The International Journal of Eating Disorders welcomes submissions from all regions of the world and representing all levels of inquiry (including basic science, clinical trials, implementation research, and dissemination studies), and across a full range of scientific methods, disciplines, and approaches.

A complete [overview](#) of the journal is given elsewhere on the journal's homepage.

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3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

The International Journal of Eating Disorders publishes the following contribution types:

1. [Original Articles](#)
2. [Brief Reports](#)
3. [Clinical Case Reports](#)
4. [Reviews](#)
5. [An Idea Worth Researching](#)
6. [Commentaries](#)

When uploading their manuscript, authors will be asked to complete a checklist indicating that they have followed the Author Guidelines pertaining to the appropriate article type. All word limits relate to the body of the text (i.e., not including abstract, references, tables and figures) and represent maximum lengths. Authors are encouraged to keep their manuscript as short as possible while communicating clearly.

1) Original Articles

These contributions report substantive research that is novel, definitive, or complex enough to require a longer communication. Only a subset of research papers is expected to warrant full-length format.

- Word Limit: 4,500 (excluding abstract, references, tables or figures)

- Abstract: 250 words.
- References: 60 are recommended; more are permissible, for cause.
- Figures/Tables: a maximum of 8 essential tables/figures, overall.

When preparing their manuscript, authors should follow the IMRaD guidelines (**I**ntroduction, **M**ethods, **R**esults, and **D**iscussion), which are recommended by the International Committee of Medical Journal Editors (ICMJE) ([J. Pharmacol. Pharmacother. 2010, 1, 42–58](#)). When preparing the Methods section, authors should refer to the [Editorial Policy on Sample Size and Statistics](#).

2) Brief Reports.

This contribution type is intended for manuscripts describing studies with straightforward research designs, pilot or “proof of concept” studies, and replications.

- Word Limit: 2,000 (excluding abstract, references, tables or figures).
- Abstract: 200 words.
- References: 20 are recommended; more are permissible, for cause.
- Figures/Tables: a maximum of 2 essential tables/figures, overall.

As for [Original Articles](#), when preparing their manuscript, authors should follow the IMRaD guidelines and comply with the [Editorial Policy on Sample Size and Statistics](#).

3) Clinical Case Reports.

Clinical Case Reports detail key elements of cases where there is novelty in the presentation, pathology or treatment, and where that novelty will inform clinicians and researchers about rare presentations or novel ideas. This category will often be appropriate to rare biological or psychological presentations. Reports of rigorously conducted studies employing single-case experimental designs are especially welcome.

Every effort should be taken to ensure the anonymity of the patient concerned, and any clinicians not involved as authors. If there is any potentially identifiable information, then it is the responsibility of the authors to obtain approval from the local Institutional Review Board (IRB) (or equivalent) for the case to be reported, and a copy of that approval should be made available to the Editor on request.

- Word Limit: 2,000 (excluding abstract, references, tables or figures).
- Abstract: 150 words.
- References: 20.
- Figures/Tables: a maximum of 2 essential tables/figures, overall.

4) Reviews.

These articles critically review the status of a given research area and propose new directions for research and/or practice. Both systematic and meta-analytic review papers are welcomed if they review a literature that is advanced and/or developed to the point of warranting a review and synthesis of existing studies. Reviews of topics with a limited number of studies are unlikely to be deemed as substantive enough for a Review paper. The journal does not accept papers that merely describe or compile a list of previous studies without a critical synthesis of the literature that moves the field the forward.

- Word Limit: 7,500 (excluding abstract, references, tables or figures).
- Abstract: 250 words.
- References: 100.
- Figures/Tables: no maximum, but should be appropriate to the material covered.

All Review articles must follow the PRISMA Guidelines (www.prisma-statement.org), summarized in a 2009 J. Clin. Epidemiol. article by Moher et al. entitled “*Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement*” (DOI: [10.1016/j.jclinepi.2009.06.005](https://doi.org/10.1016/j.jclinepi.2009.06.005)), freely available for download in both English and Spanish.

Authors who choose this contribution type must complete the Review Checklist upon submission of the manuscript, an example of which can be found [here](#)). This example is for informational purposes only. During the submission process, authors will be prompted to complete the Review Checklist directly in ScholarOne. The rationale for any unchecked items on the Review Checklist must be explicitly described in the accompanying Cover Letter.

5) An Idea Worth Researching

This is a contribution type where authors propose an idea that may not yet have adequate empirical support or be ready for full empirical testing, but holds great promise for advancing research of eating disorders. Authors are encouraged to write a piece that is bold, forward looking, and suggestive of new and exciting avenues for research and/or practice in the field.

- Word Limit: 2,000 (excluding abstract, references, tables or figures).
- Abstract: no abstract.
- References: 5 maximum, in footnote format.
- Figures/Tables: a maximum of 2 essential tables/figures, overall.

6) Commentaries

Commentaries are solicited by the Editors when multiple perspectives on or critical appraisal of an article would assist in placing that article in context. Unsolicited commentaries are not considered for publication.

- Word Limit: 2,000 (excluding abstract, references, tables or figures).
- Abstract: no abstract.
- References: 5, using the footnote format rather than the journal's standard format.
- Figures/Tables: none.

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4. PREPARING THE SUBMISSION

Parts of the Manuscript

The submission should be uploaded in separate files: 1) [manuscript file](#); 2) [figures](#); 3) [Supporting Information file\(s\)](#).

1. Manuscript File

The text file should contain all of the manuscript text, including the tables and figure legends. The text should be presented in the following order:

- i. [Title](#)
- ii. A short running title of less than 40 characters
- iii. The full names of all [authors](#)

- iv. The authors' institutional affiliations where the work was conducted, with a footnote for an author's present address if different to where the work was carried out
- v. [Acknowledgements](#)
- vi. [Abstract](#) and [Keywords](#)
- vii. [Main text](#)
- viii. [References](#)
- ix. [Tables](#) (each table complete with title and footnotes)
- x. [Figure legends](#)

Title

The title should be short and informative, containing major keywords related to the content. The title should not contain abbreviations (see [Wiley's best practice SEO tips](#)).

Authorship

For details on eligibility for author listing, please refer to the journal's [Authorship policy](#) outlined in Section 5 of these Author Guidelines.

Acknowledgments

Contributions from individuals who do not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors will be asked to provide a conflict of interest statement during the submission process. See the journal's policy on [Conflict of Interest](#) outlined in Section 5 of these Author Guidelines. Authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Abstract

The word maximum and abstract format varies by contribution type (see above). When an abstract is required, the abstract should be typed as a single paragraph. The journal requires **structured abstracts** with two exceptions: the journal will continue to use unstructured abstracts for Clinical Case Reports, and no abstract is required for "An Idea Worth Researching".

Structured abstracts should be organized as follows: **Objective:** briefly indicate the primary purpose of the article, or major question addressed in the study. **Method:** indicate the sources of data, give brief overview of methodology, or, if review article, how the literature was searched and articles selected for discussion. For research based articles, this section should briefly note study design, how participants were selected, and major study measures. **Results:** summarize the key findings. **Discussion:** indicate main clinical, theoretical, or research applications/implications.

Keywords

Please provide five to seven keywords. Keywords should be taken from those recommended by the US National Library of Medicine's Medical Subject Headings (MeSH) browser list at www.nlm.nih.gov/mesh.

Main Text

- Authors should refrain from using terms that are stigmatizing or terms that are ambiguous. For further explanation and examples, see the 2016 IJED article by Weissman et al. entitled "*Speaking of that: Terms to avoid or reconsider in the eating disorders field*" (DOI: [10.1002/eat.22528](https://doi.org/10.1002/eat.22528)).
- The text should be divided as outlined in Section 3 "[Manuscript Categories and Requirements](#)".
- Manuscripts reporting original research should follow the **IMRaD guidelines** (Introduction, (Methods, Results, and Discussion), which are recommended by the International Committee of Medical Journal Editors (ICMJE) ([J. Pharmacol. Pharmacother. 2010, 1, 42–58](#)).
- To facilitate evaluation by the Editors and Reviewers, each manuscript page should be numbered; and line numbers should be applied (restarting from 1 on each page). Instructions on how to implement this feature in Microsoft Word are given [here](#).
- The journal uses US spelling. Authors may submit using any form of English as the spelling of accepted papers is converted to US English during the production process.
- Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.
- It is the primary responsibility of the authors to proofread thoroughly and ensure correct spelling and punctuation, completeness and accuracy of references, clarity of expression, thoughtful construction of sentences, and legible appearance prior to the manuscript's submission.
- Authors for whom English is not their first language are encouraged to seek assistance from a native or fluent English speaker to proof read the manuscript prior to submission. Wiley offers a paid service that provides expert help in English language editing—further details are given [below](#).

- Articles reporting data taken from or deposited elsewhere should refer to the journal policy on [Data Storage and Documentation](#) in Section 5 (below).

References

References in all manuscripts should follow the style of the American Psychological Association (6th edition), except in regards to spelling. The APA website includes [a range of resources for authors learning to write in APA style](#), including [An overview of the Publication Manual of the American Psychological Association, Sixth Edition](#); includes [free tutorials on APA Style basics](#) and an [APA Style Blog](#). Please note APA referencing style requires that a Digital Object Identifier (DOI) be provided for all references where available.

Tables

Each table must be numbered in order of appearance in the text with Arabic numerals and be cited at an appropriate point in the text. Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files (i.e., created in Microsoft Word or similar), not pasted as images. Legends should be concise but comprehensive—the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as standard deviation (SD) or standard error of the mean (SEM) should be identified in the headings. The journal's [Editorial Policy on Sample Size and Statistics](#) is given in Section 5.

Figure Legends/Captions

Each figure caption should have a brief title that describes the entire figure without citing specific panels, followed by a description of each panel. Captions should be concise but comprehensive—the figure and its caption must be understandable without reference to the text. Be sure to explain abbreviations in figures even if they have already been explained in-text. Axes for figures must be labeled with appropriate units of measurement and description. Include definitions of any symbols used and units of measurement.

2. Figures

Although authors are encouraged to send the highest quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted. [Click here](#) for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Helvetica typeface is preferred for lettering within figures. All letters, numbers and symbols must be at least 2 mm in height. Courier typeface should be used for sequence figures. Figures should be numbered consecutively with Arabic numerals, and they should be numbered in the order in which they appear in the text.

Figures should be submitted as electronic images to fit either one (55 mm, 2 3/16", 13 picas), two (115 mm, 4 1/2", 27 picas), or three (175 mm, 6 7/8", 41 picas) columns. The length of an illustration cannot exceed 227 mm (9"). Journal quality reproduction requires grey scale and color files at resolutions of 300 dpi. Bitmapped line art should be submitted at resolutions of 600–1200 dpi.

Figures submitted in color will be reproduced in color online free of charge. Authors wishing to have figures printed in color in hard copies of the journal will be charged a fee by the Publisher; further details are given [elsewhere](#) in these Author Guidelines. Authors should note however, that it is preferable that line figures (e.g., graphs) are supplied in black and white so that they are legible if printed by a reader in black and white.

3. Supporting Information Files(s)

Supporting information is information that is not essential to the article, but provides greater depth and background. If an article is accepted for publication, the Supporting Information is hosted online together with the article and appears without editing or typesetting. It may include, but is not limited to, video clips, large sections of tabular data, program code, or electronic graphical files that are otherwise not suitable inclusion in the main article. [Click here](#) for Wiley's FAQs on Supporting Information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

Supporting Information must be submitted at the time of peer review. The availability of this material should be indicated in the text of the article where appropriate.

General Style Points

The following points provide general advice on formatting and style.

- **Terminology:** Terms such as "anorexics" or "bulimics" as personal pronouns, referring to groups of individuals by their common diagnosis, should be avoided. Terms like "individuals with anorexia nervosa", "people with bulimia nervosa", or "participants with eating disorders" should be used instead. Note, "participants" should be used in place of "subjects".

- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website at www.bipm.fr for more information about SI units.
- **Numbers** under 10 should be spelt out, except for: measurements with a unit (8 mmol/L); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
- **The word “data”** is plural; therefore, text should follow accordingly (for example, “The data show...the data are ... the data were...”).
- **Sex/Gender & Age:** When referring to sex/gender, “males” and “females” should be used only in cases where the study samples include both children (below age 18) and adults and only if word limit precludes using terms such as “male participants/female participants,” “female patients/male patients”; when the participants comprise adults only, the terms “men” and “women” should be used. In articles that refer to children, “boys” and “girls” should be used.
- **Trade Names:** Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.
- **Statistics:** Authors should adhere to the journal’s policy on [Sample Size and Statistics](#) when reporting studies. For information on how to present p values and other standard measurements see IJED Statistical Formatting Requirements

